STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH

Jeffrey A. Meyers
Commissioner

Katja S. Fox
Director

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April 26, 2016

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Behavioral Health, Bureau of Drug and Alcohol Services, to enter into an Agreement with Goodwin Community Health, 311 Route 108, Somersworth, NH, 03878 (Vendor #156668-B001) provide substance use disorder treatment and recovery support services statewide, in an amount not to exceed $489,500, effective upon approval by Governor and Executive Council through June 30, 2017. 56.1% Federal, 29.4% General, and 14.5% Other Funds.

Funds to support this request are available in State Fiscal Years 2016 and 2017 in the following accounts, with the authority to adjust encumbrances between State Fiscal Years through the Budget Office if needed and justified, without approval of the Governor and Executive Council.

05-95-49-491510-2989 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: DIV OF COMM BASED CARE SVC, BUREAU OF DRUG & ALCOHOL SVCS, GOVERNOR COMMISSION FUNDS

State Fiscal Year	Class/Account	Title	Budget Amount
2016	102-500734	Contracts for Prog Svc	$11,748
2017	102-500734	Contracts for Prog Svc	$61,677
Sub-total			$73,425

05-95-49-491510-2990 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: DIV OF COMM BASED CARE SVC, BUREAU OF DRUG & ALCOHOL SVCS, CLINICAL SERVICES (34.4% General 65.6% Federal)

State Fiscal Year	Class/Account	Title	Budget Amount
2016	102-500734	Contracts for Prog Svc	$86,152
2017	102-500734	Contracts for Prog Svc	$329,923
Sub-total			**$416,075**
Grand Total			**$489,500**

EXPLANATION

This Agreement represents the last of fifteen (15) agreements with a combined price limitation of $11,940,600. On March 23, 2016 (Item #6), Governor and Executive Council approved 14 Agreements with a combined price limitation of $11,451,100.

This Agreement will allow Contractor to provide an array of Substance Use Disorder Treatment and Recovery Support Services statewide to children and adults with substance use disorders, who have income below 400% the Federal Poverty level and are residents of New Hampshire or are homeless in New Hampshire. (See attached Summary of Contracted Services by Vendor). Substance use disorders occur when the use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. The existence of a substance use disorder is determined using a clinical evaluations based on Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition criteria.

This Agreement is part of the Department's overall strategy to respond to the opioid epidemic that continues to negatively impact New Hampshire's individuals, families, and communities as well as to respond to other types of substance use disorders. In 2014 there were 325 drug overdose deaths in New Hampshire with the death toll for 2015 at 431 as of March 28, 2016; however, the 2015 statistics are expected to increase as cases are still pending analysis.

The Department published a Request for Proposals for Substance Use Disorder Treatment and Recovery Support Services (RFP #16-DHHS-DCBCS-BDAS-03) on the Department of Health and Humans Services website November 3, 2015 to December 15, 2015. The Department received fifteen proposals. These proposals were reviewed and scored by a team of individuals with program specific knowledge. The Department selected all the Vendors to provide these services (See attached Summary Score Sheet).

Some of the Vendors' proposals scored lower than anticipated; however, it was determined that losing substance use disorder treatment and recovery support services in the midst of an Opioid Crisis would be detrimental to the individuals, families, and communities of New Hampshire. In order to ensure effective delivery of services, the Department has strengthened language in the Vendors' contracts.

The Contract includes language to assist pregnant and parenting women by providing interim services if they are on a waitlist, to ensure clients have faster access to services by maintaining and monitoring a waitlist on an agency and statewide level, to ensure clients contribute to the cost of services by assessing client income at intake and on a monthly basis, and to ensure care coordination for the clients by assisting them with accessing services or working with a client's existing provider for physical health, behavioral health, medication assisted treatment and peer recovery support services.

The Department will monitor the performance of this Vendor by monitoring monthly reports, quarterly utilization, completing site visits, and reviewing client records. In addition, the Department is developing a Quality Monitoring and Improvement Plan to manage the performance of these contracts.

The attached Contract includes language that reserves the right to renew each contract for up to two (2) additional years, subject to the continued availability of funds, satisfactory performance of contracted services and Governor and Executive Council approval.

Should the Governor and Executive Council determine to not authorize this Request, the Contractor would not have sufficient resources to promote and provide the array of services necessary to provide individuals with substance use disorders, the necessary tools to achieve, enhance and sustain recovery. In addition, failure to obligate the federal funds in the Substance Abuse Prevention and Treatment Block Grant to community based programs to provide alcohol and other drug treatment services could result in the loss of Federal Block Grant funds made available for these services.

Area served: Statewide.

Source of Funds: 56.1% Federal Funds from the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Substance Abuse Prevention and Treatment Block Grant, CFDA #93.959, Federal Award Identification Number TI010035-14, and 29.4% General Funds and 14.5% Other Funds from the Governor's Commission on Alcohol and Other Drug Abuse Prevention, Intervention and Treatment.

In the event that the Federal Funds become no longer available, General Funds will not be requested to support this program.

Respectfully submitted

Katja S. Fox
Director

Approved by:

Jeffrey A. Meyers
Commissioner

Summary of Contracted Services by Vendor

Substance Use Disorder Treatment Services and Recovery Support Services:	Individual Outpatient	Group Outpatient	Intensive Outpatient	Partial Hospitalization	Transitional Living	Low-Intensity Residential	High-Intensity Residential	High-Intensity Residential for Pregnant and Parenting Women	Ambulatory WM w/o Extended On-Site Monitoring (ASM Level 1WM)	Medically Monitored Inpatient Withdrawal Management (ASAM Level 3.7 WM)	Medication Assisted Treatment	Continuous Recovery Monitoring	Enhanced Recovery Support Services	Individual Recovery Support Services (non-clincial)	Group Recovery Support Services (non-clincial)	Statewide Crisis	Crisis services to agnecy's own clients
Vendors:																	
Concord Hosptial, Inc.	x	x	x									x		x			x
Families First of the Greater Seacoast	x										x	x	x	x	x		x
Families in Transition	x	x	x									x	x	x			x
Goodwin Community Health	x	x	x								x	x	x	x	x		x
Grafotn County DOC	x	x										x		x			x
Greater Nashua Council on Alcoholism, Inc.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
HALO Educational Systems	x	x										x	x	x	x		x
Headrest, Inc.	x	x	x			x						x	x	x	x		x
Horizons Counseling Center, Inc.	x	x	x								x	x		x	x		x
Manchester Alcoholism Rehabilitation Center (subsidiary of Easter Seals New Hampshire Inc.) - Total	x	x	x	x	x	x	x			x		x		x	x		x
National Council on Alacoholism and Drug Dependency/Greater Manchester	x	x	x	x	x	x	x		x			x		x	x		x
Phoenix Houses of New England - Total	x	x	x		x		x				x	x		x			x
South Eastern New Hampshire Alcohol and Drug Abuse Services	x	x	x			x	x					x		x			x
Tri-County Community Action Program, Inc.	x	x	x			x	x				x	x		x			x
The Youth Council	x	x										x		x			x

An "X" indicates that the Vendor will provide the corresponding contracted service.

New Hampshire Department of Health and Human Services
Office of Business Operations
Contracts & Procurement Unit
Summary Score Sheet

Substance Use Disorder Treatment and Recovery Support Services
RFP Name

(RFP) #16-DHHS-DCBCS-BDAS-03
RFP Number

Bidder Name	Maximum Points	Actual Points
1. Concord Hosptial, Inc.	945	687
2. Families First of the Greater Seacoast	945	715
3. Families in Transition	945	751
4. Goodwin Community Health	945	587
5. Grafotn County	945	492
6. Greater Nashua Council on Alcoholism, Inc.	945	820
7. HALO Educational Systems	945	460
8. Headrest, Inc.	945	390
9. Horizons Counseling Center, Inc.	945	717
10. Manchester Alcoholism Rehabilitation Center (subsidiary of Easter Seals New Hampshire Inc.)	945	661
11. National Council on Alcoholism and Drug Dependency/Greater Manchester	945	684
12. Phoenix Houses of New England	945	626
13. South Eastern New Hampshire Alcohol and Drug Abuse Services	945	562
14. Tri-County Community Action Program, Inc.	945	570
15. The Youth Council	945	515

Reviewer Names

1. Jaime Powers, BDAS Clinical Services Unit Administrator
2. Linda Parker, BDAS Program Specialist IV
3. Paul Kiernan, BDAS Program Specialist IV
4. Michele Harlan, DHHS Director of Mental Health Services
5. Rhonda Siegel, DPHS, Administrator II
6. Donna Ferland, NH Hospital Administrator III / Financial Mngr
7. P. J. Nadeau, DHHS Financial Manager
8. Ann Driscoll, Administrator

Subject: Substance Use Disorder Treatment and Recovery Support Services (16-DHHS-DCBCS-BDAS-03-SUBST-04)

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Goodwin Community Health		1.4 Contractor Address 311 Route 108 Somersworth, NH 03878	
1.5 Contractor Phone Number 603 516-2550	1.6 Account Number 05-95-49-491510-29890000-102-500734; 05-95-49-491510-29900000-102-500734	1.7 Completion Date June 30, 2017	1.8 Price Limitation $489,500.
1.9 Contracting Officer for State Agency Eric Borrin, Director		1.10 State Agency Telephone Number 603-271-9558	
1.11 Contractor Signature Janet Lautsch		1.12 Name and Title of Contractor Signatory Janet Lautsch CEO	

1.13 Acknowledgement: State of NH, County of Strafford

On April 11, 2016, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public or Justice of the Peace

[Seal] exp. 11/6/2018

1.13.2 Name and Title of Notary or Justice of the Peace

Sherry Trask

1.14 State Agency Signature Date: 4/28/16	1.15 Name and Title of State Agency Signatory Katja S Fox, Director

1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)*

By: Director, On:

1.17 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)*

By: Megan A. Lyde Attorney On: 5/16/14

1.18 Approval by the Governor and Executive Council *(if applicable)*

By: On:

2. EMPLOYMENT OF CONTRACTOR/SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT A which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.
3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.18, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.14 ("Effective Date").
3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.
Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds, and in no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to terminate this Agreement immediately upon giving the Contractor notice of such termination. The State shall not be required to transfer funds from any other account to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.
5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT B which is incorporated herein by reference.
5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.
5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.
5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.
6.1 In connection with the performance of the Services, the Contractor shall comply with all statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal opportunity laws. This may include the requirement to utilize auxiliary aids and services to ensure that persons with communication disabilities, including vision, hearing and speech, can communicate with, receive information from, and convey information to the Contractor. In addition, the Contractor shall comply with all applicable copyright laws.
6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.
6.3 If this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all the provisions of Executive Order No. 11246 ("Equal Employment Opportunity"), as supplemented by the regulations of the United States Department of Labor (41 C.F.R. Part 60), and with any rules, regulations and guidelines as the State of New Hampshire or the United States issue to implement these regulations. The Contractor further agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.
7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.
7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this

Contractor Initials JL
Date 4-11-16

Agreement. This provision shall survive termination of this Agreement.
7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

8. EVENT OF DEFAULT/REMEDIES.
8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):
8.1.1 failure to perform the Services satisfactorily or on schedule;
8.1.2 failure to submit any report required hereunder; and/or
8.1.3 failure to perform any other covenant, term or condition of this Agreement.
8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:
8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely remedied, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;
8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;
8.2.3 set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or
8.2.4 treat the Agreement as breached and pursue any of its remedies at law or in equity, or both.

9. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.
9.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.
9.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.
9.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

10. TERMINATION. In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT A.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS. The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice and consent of the State. None of the Services shall be subcontracted by the Contractor without the prior written notice and consent of the State.

13. INDEMNIFICATION. The Contractor shall defend, indemnify and hold harmless the State, its officers and employees, from and against any and all losses suffered by the State, its officers and employees, and any and all claims, liabilities or penalties asserted against the State, its officers and employees, by or on behalf of any person, on account of, based or resulting from, arising out of (or which may be claimed to arise out of) the acts or omissions of the Contractor. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.
14.1 The Contractor shall, at its sole expense, obtain and maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:
14.1.1 comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000per occurrence and $2,000,000 aggregate ; and
14.1.2 special cause of loss coverage form covering all property subject to subparagraph 9.2 herein, in an amount not less than 80% of the whole replacement value of the property.
14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

Contractor Initials JL
Date 4-11-16

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than thirty (30) days prior to the expiration date of each of the insurance policies. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference. Each certificate(s) of insurance shall contain a clause requiring the insurer to provide the Contracting Officer identified in block 1.9, or his or her successor, no less than thirty (30) days prior written notice of cancellation or modification of the policy.

15. WORKERS' COMPENSATION.
15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation").*
15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. WAIVER OF BREACH. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

17. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

18. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

19. CONSTRUCTION OF AGREEMENT AND TERMS. This Agreement shall be construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional provisions set forth in the attached EXHIBIT C are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire Agreement and understanding between the parties, and supersedes all prior Agreements and understandings relating hereto.

Contractor Initials JL
Date 4-11-16

Scope of Services

1. Provisions Applicable to All Services

1.1. The Contractor will submit a detailed description of the language assistance services they will provide to persons with limited English proficiency to ensure meaningful access to their programs and/or services within ten (10) days of the contract effective date.

1.2. The Contractor agrees that, to the extent future legislative action by the New Hampshire General Court or federal or state court orders may have an impact on the Services described herein, the State Agency has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

2. Definitions

2.1. Adolescents: Adolescents are individuals under the age of 18.

2.2. American Society of Addiction Medicine (ASAM): ASAM is a professional society representing over 3,500 physicians, clinicians and associated professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction. More information can be found at: http://www.asam.org/

2.3. American Society of Addiction Medicine Criteria: ASAM's criteria, formerly known as the ASAM patient placement criteria, is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-orientated and results-based care in the treatment of addiction. Today the criteria have become the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions. ASAM's criteria are required in over 30 states. More information can be found at: http://www.asam.org/publications/the-asam-criteria

2.4. Charitable Choice: Charitable Choice is Public Law 102-321, 102d Congress and amended in 1992 and again in 2000 (Children's Health Services Act). Charitable Choice is a federal legislative provision designed to remove barriers to faith-based organizations receiving certain Federal funds. States may allocate Block Grant funds to faith-based treatment and recovery support services programs that maintain their religious character and hire people of their same faith, who also meet state requirements for licensing or certification of substance abuse treatment and recovery support services programs and staff. The Charitable Choice final rules were published in the Federal Register on September 30, 2003.

2.5. Clinical Evaluation: A Clinical Evaluation is a biopsychosocial evaluation completed in accordance with Technical Assistance Publication (TAP) 21: Addiction Counseling Competencies, available at http://store.samhsa.gov/product/TAP-21-Addiction-Counseling-Competencies/SMA15-4171.

2.6. Days: Days in this Exhibit A and Exhibit B refers to calendar days, unless otherwise noted.

2.7. Evidence-Based Practice: Evidence-Based Practice is applying the best available research results (evidence) when making decisions about health care. Health care professionals who perform evidence-based practice use research evidence along with clinical expertise and patient preferences. Systematic reviews (summaries of health care research results) provide information that aids in the process of evidence-based practice.

2.7.1. The service shall be included as an evidence-based mental health and substance abuse intervention on the SAMHSA National Registry of Evidence-Based Programs and Practices (NREPP), http://www.nrepp.samhsa.gov/ViewAll.aspx

2.7.1.1. The service shall be included as an evidence-based mental health and substance abuse intervention on the SAMHSA National Registry of Evidence-Based Programs and Practices (NREPP), http://www.nrepp.samhsa.gov/ViewAll.aspx

2.7.1.2. The services shall be published in a peer-reviewed journal and found to have positive effects; or

2.7.1.3. The SUD treatment service provider shall be able to document the services' effectiveness based on the following:

1. The service is based on a theoretical perspective that has validated research; or
2. The service is supported by a documented body of knowledge generated from similar or related services that indicate effectiveness;

2.8. Homeless: Homeless is (1) an individual or family who lacks a fixed, regular, and adequate nighttime residence; or (2) an individual or family who has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels and congregate shelters), an institution other than a penal facility that provides temporary residence for individuals intended to be institutionalized, or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

2.9. Level of Care: Level of care refers to the intensity of treatment defined by the American Society of Addiction Medicine (ASAM) October 2013.

2.10. New Hampshire Resident: A New Hampshire resident is defined as a person residing in New Hampshire regardless of how long they have resided in New Hampshire or whether or not they have a fixed or permanent address.

2.11. Resiliency and Recovery Oriented Systems of Care (RROSC): RROSC are networks

of organizations, agencies, and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat substance use problems and disorders. RROSCs support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness, and recovery from alcohol and drug problems. In New Hampshire, this is operationalized by the Continuum of Care model.

2.12. Screening Positive for Substance Use Disorder: Screening positive for a Substance Use Disorder means that the individual is likely to meet the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5) criteria for a Substance Use Disorder. If the client screens probable, a clinical evaluation will be required to determine if the client does in fact meet DSM 5 criteria for a Substance Use Disorder.

2.13. Substance Abuse Prevention and Treatment (SAPT) Block Grant: SAPT Block Grant was originally established by Public Law 97-35 (PL 97-35), creating the Alcohol, Drug Abuse and Mental Health Services Block Grant (later the Substance Abuse Prevention and Treatment Block Grant, and now the Behavioral Health Assessment and Plan), which became effective on October 1, 1992 for the purpose of carrying out and evaluating activities to prevent and treat substance abuse and dependence.

2.14. Substance use disorders occur when the use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. The existence of a substance use disorder is determined using Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5) criteria.

2.15. Web Information Technology System (WITS): WITS is a secure, 24/7 accessible web-based information technology system for the purpose of storing client demographic information. All BDAS contracted providers use WITS to report on the National Outcome Measures (NOMs) established by the SAMHSA, as required in the Federal Substance Abuse Prevention and Treatment Block Grant.

3. Covered Populations

3.1. The Contractor shall provide services in this Contract to the general population in Section 3.2 who:

3.1.1. Have a substance use disorder; and

3.1.2. Have income below 400% Federal Poverty Level; and

3.1.3. Are Residents of New Hampshire; or

3.1.4. Are homeless in New Hampshire.

3.2. The Contractor agrees to provide services in this Contract to the general client

population that includes, but not limited to:

3.2.1. Adolescents;

3.2.2. Adults

3.2.3. Pregnant women;

3.2.4. Women with dependent children;

3.2.5. Injection drug users;

3.2.6. Individuals with co-occurring substance use and mental health disorders;

3.2.7. Veterans; and/or

3.2.8. Individuals who are involved with the criminal justice system.

3.3. The Contractor shall provide services in this Contract separately for adolescents and adults unless approved by the Department.

4. Substance Use Disorder Treatment Services

4.1. The Contractor is required to provide to eligible individuals the following substance use disorder treatment services:

4.1.1. Outpatient Treatment as defined as American Society of Additional (ASAM) Criteria, Level 1. Outpatient Treatment services assist an individual or group of individuals to achieve treatment objectives through the exploration of substance use disorders and their ramifications, including an examination of attitudes and feelings, and consideration of alternative solutions and decision making with regard to alcohol and other drug related problems.

4.1.2. Intensive Outpatient Treatment as defined as ASAM Criteria, Level 2.1. Intensive Outpatient Treatment services provide intensive and structured individual and group alcohol and/or other drug treatment services and activities that are provided according to an individualized treatment plan that includes a range of outpatient treatment services and other ancillary alcohol and/or other drug services. Services for adults are provided at least 3 hours a day and at least 3 days a week. Services for adolescents are provided at least 2 hours a day and at least 3 days a week.

4.1.3. Integrated Medication Assisted Treatment services provide for medication prescription and monitoring for treatment of opiate and other substance use disorders. The Contractor shall provide non-medical treatment services to the client in conjunction with the medical services provided either directly by the Contractor or by an outside medical provider. The Contractor shall be responsible for coordination of care and meeting all requirements for the service provided. The Contractor shall deliver Integrated Medication Assisted Treatment services accordance with guidance provided by the Department, "Guidance Document on Best Practices: Key Components for Delivery Community-Based

Medication Assisted Treatment Services for Opioid Use Disorders in New Hampshire."

4.1.3.1. Notwithstanding Section 3.2.1, the Vendor shall provide Integrated Medication Assisted Treatment Services to individuals 18 and older.

4.2. The Contractor shall submit for Department approval, within 30 days from the contract effective date, a list of the service components that comprise the substance use disorder treatment services including the frequency of those components for Intensive Outpatient Treatment services in Section 4.1.2..

4.3. The Contractor shall submit for Department approval, within 30 days from the contract effective date, the evidenced based practices to be used for all services in Section 4.1.

4.4. The Contractor shall submit for Department approval, changes to service components in Section 4.2 and to evidence-based practices in Section 4.3, within 30 days prior to making the changes effective.

5. Crisis Services to Existing Clients or their Significant Others

5.1. The Contractor shall provide Crisis Services to existing clients or their significant others as follows:

5.1.1. Provide Crisis Services, during normal business hours defined as 8 am to 5 pm, Monday through Friday either in person or by telephone that:

5.1.1.1. Assist individuals in addressing a current crisis related to their substance use disorder or the substance use disorder of a significant other;

5.1.1.2. Provide counseling services to assist with client stabilization, assessment of client's psychological stability and risk for harming themselves or others and appropriate referral based on this assessment; and

5.1.1.3. Refer clients to appropriate treatment and other resources in the client's service area.

5.1.1.4. If a request for crisis services comes from an individual who is not a current client, that individual may be referred to the statewide crisis services provider.

5.1.2. Provide encounter notes in the client's health record.

5.1.3. Provide sufficient staffing to provide Crisis Services as described above at least during normal business hours defined as 8 am to 5 pm, Monday through Friday.

5.1.4. Shall refer clients to the Statewide Crisis Services hotline, after normal business hours.

5.2. The Contractor agrees that Crisis Services shall be considered individual outpatient

services when the Crisis Service provided has the specific purpose of treating the individual's substance use disorder.

5.3. The Contractor agrees that Crisis Services shall be considered individual recovery support services (non-clinical) when the Crisis service provided has the purpose of reducing or removing a barrier to the client achieving or maintaining recovery without directly treating the substance use disorder.

6. Recovery Support Services

6.1. The Contractor shall provide Recovery Support Services such as:

6.1.1. Enhanced services remove barriers to a client's participation in treatment or recovery or reduce or remove threats to a client's maintaining participation in treatment and/or recovery such as transportation or child care.

6.1.1.1. Enhanced services include only direct services to the client such as providing transportation to treatment appointments or providing childcare while a client attends a treatment appointment.

6.1.1.2. Enhanced services do not include indirect costs such as marketing, staff training, or staff travel unless such expenses can be shown to be required in order to provide the enhanced service.

6.1.1.3. Submitting for Department approval, within 30 days from the contract effective date, a list and a description of the direct services that will be provided under Enhanced Services.

6.1.2. Non-clinical services such as but not limited to parenting, job search, financial management, skills development, and paraprofessional counseling services by:

6.2.1.1. A Certified Recovery Support Worker (CRSW) under the supervision of a Masters Licensed Alcohol and Drug Counselor (MLADC): or

6.2.1.2. A Certified Recovery Support Worker (CRSW) under the supervision of a Licensed Alcohol and Drug Counselor (LADC) with a Licensed Clinical Supervisor (LCS); or

6.2.1.3. A MLADC or LADC

6.2.1.4. Submitting for Department approval, within 30 days from the contract effective date, the name and description of the activities/services to provide non-clinical services.

7. Enrolling Clients for Services

7.1. The Contractor shall complete Intake Screenings and ASAM Level of Care Assessments, as follows:

7.1.1. Have direct contact (face to face communication by meeting in person, or

electronically, or by telephone conversation) with an individual within two (2) business days from the date that individual (defined as a non-client, existing client, other provider, or any other person or entity) contacts the Contractor for Substance Use Disorder Treatment and Recovery Support Services.

7.1.2. Complete an initial Intake Screening within two (2) business days from the date of the first direct contact with the individual, using the eligibility module in Web Information Technology System (WITS) to determine probability of being eligible for services under this contract and for probability of having a substance use disorder.

7.1.3. Assess clients' income prior to admission using the WITS fee determination model and assure that clients' income information is updated as needed over the course of treatment by asking clients about any changes in income no less frequently than every 4 weeks.

7.1.4. Complete an ASAM Level of Care Assessment for all services in Section 4, within two (2) days of the initial Intake Screening in (Section 7.1.2) using the ASI Lite module, in WITS or in another electronic medical/health record system, or an alternative assessment tool as directed by the Department, when the individual is determined probable of being eligible for services. .

7.1.5. Make available to the Department upon request, the data from the ASAM Level of Care Assessment and in a format approved by the Department, when using an electronic medical/health record system other than WITS.

7.1.6. The Contractor shall complete a clinical evaluation of clients for services in Section 4, as follows:

7.1.6.1. Prior to admission as a part of interim services or within 3 days following admission, and during treatment only when determined by licensed clinician.

7.2. The Contractor shall determine client eligibility for services under this contract using the eligibility criteria as follows:

7.2.1. The individual's income must be below 400% of Federal Poverty Level (FPL);

7.2.2. The individual must be a resident of New Hampshire or homeless in New Hampshire;

7.2.3. The individual must be determined positive for a substance use disorder (as evidenced in their clinical evaluation, Section 7.1.6

7.2.4. The individual is eligible for services described in Section 4 as determined by the ASAM Level of Care Assessment (defined in Section 7.1.4) unless:

7.2.4.1. The client choses to receive a service with a lower ASAM Level of Care; or

7.2.4.2. The service with the needed ASAM Level of Care is unavailable at the time the level of care is determined in Section 7.1.4, in which case the client may chose:

1. A service with a lower ASAM Level of Care;
2. A service with the next available higher ASAM Level of Care;
3. Be placed on the waitlist until their service with the assessed ASAM Level of Care becomes available as in Section 7.1.4; or
4. Be referred to another agency in the client's service area that provides the service with the needed ASAM Level of Care.

7.3. The Contractor agrees to provide services to all eligible clients who:

7.3.1. Receive Medication Assisted Treatment services from other providers such as a client' primary care provider;

7.3.2. Have co-occurring mental health disorders; or

7.3.3. Are on medications and are taking those medications as prescribed regardless of the class of medication.

7.4. The Contractor shall admit eligible clients for services according to the order of priority described below:

7.4.1. Pregnant women and women with dependent children, even if the children are not in their custody, as long as parental rights have not been terminated, including the provision of interim services within the required 48 hour time frame. If the contractor is unable to admit a pregnant woman for the needed level of care within 24 hours, the contractor shall:

7.4.1.1. Assist the pregnant woman with identifying alternative providers and with accessing services with these providers. This assistance must include actively reaching out to identify providers on the behalf of the client.

7.4.1.2. Provide interim services until the appropriate level of care becomes available at either the contractor agency or an alternative provider. Interim services shall include:

1. At least one 60 minute individual or group outpatient session per week;
2. Recovery support services as needed by the client;
3. Daily calls to the client to assess and respond to any emergent needs.

7.4.2. Individuals who have been administered Narcan to reverse the effects of an

opioid overdose either in the 14 days prior to screening or in the period between screening and admission to the program.

7.4.3. Individuals with a history of injection drug use including the provision of interim services within 14 days.

7.4.4. Individuals with substance use and co-occuring mental health disorders.

7.4.5. Individuals with Opioid Use Disorders.

7.4.6. Veterans with substance use disorders

7.4.7. Individuals with substance use disorders who are involved with the criminal justice system.

7.4.8. Individuals who require priority admission at the request of the Department.

7.5. The Contractor shall obtain consent from individuals prior to providing services as follows:

7.5.1. For individuals whose age is 12 and older, the Contractor is required to obtain consent from the individual themselves; or

7.5.2. For individuals whose age is under 12, the Contractor is required to obtain consent from the individual's parent or legal guardian.

8. Waitlist

8.1. The Contractor shall place an eligible individual on a statewide waitlist in WITS when the service with the appropriate ASAM Level of Care (as defined in 7.1.4) is not available for the client at the time of screening as in Section 7.2.4.2.

8.1.1. The Contractor shall keep the client's information up to date on the statewide waitlist.

8.1.2. The Contractor shall notify the Department within 30 days from the effective date of the contract, with the name of the staff person who is responsible to monitoring and maintaining the waitlist.

8.1.3. The Contractor shall monitor the waitlist and ensure that clients begin services as soon as possible either under this contract or by a referral to an agency that has an earlier available opening as follows:

8.1.3.1. Anytime a client contacts the agency for a service and that service is not available within 2 business days of contact, they must be immediately added to the agency's waitlist and to the waitlist of other agencies as appropriate.

8.1.3.2. Anytime a client is getting ready to move to a new level of care that will not be provided by the current provider or for which the current provider has a waitlist, the provider shall add the client to the waitlist of other appropriate agencies.

8.1.3.3. Anytime a client is added to the waitlist of another agency, the provider shall complete consent in WITS to allow the agency the client is being referred to review client information in WITS.

8.1.3.4. Every business day, the staff member identified in 8.1.2 shall review pending clients from outside agencies to accept, reject or delete the client as appropriate.

8.1.3.5. Every business day, the staff member identified in 8.1.2 shall review their agency waitlist to ensure that any clients who were on the agency waitlist who are no longer on the waitlist due to admission, inaccessibility, etc. have been removed from the waitlist.

8.1.4. The Contractor shall provide a client on the waitlist interim services, defined as recovery support services or services with a lower ASAM Level of Care, under this contract or by referral to an agency that has an earlier available opening in the client's service area.

9. Client Fees and Assistance with Enrolling in Insurance Programs

9.1. The Contractor agrees to collect allowable fees from clients and to assist them with enrolling in private or public insurance programs when appropriate, as follows:

9.1.1. Agrees to using the Sliding Fee Scale and charging the client for their share for services in accordance with Exhibit B.

9.1.2. Agrees not to delay a client's admittance into a Substance Use Disorder Treatment and Recovery Support Services program for services due to a client's inability to immediately pay his or her share of the allowable fees (in accordance with Exhibit B) or pending an insurer's payment

9.1.3. Agrees to assist clients, who are unable to secure financial resources necessary for initial entry into the program, with obtaining other potential sources such as:

9.1.3.1. Assess the client's appropriateness for enrollment in public or private insurance, including but not limited to Medicaid and New Hampshire Health Protection Program, and assist the client in enrolling in an appropriate public or private insurance program; and/or

9.1.3.2. Complete assistance at or before intake, but no later than 14 days after intake.

9.1.3.3. Develop payment plans.

9.1.3.4. Document the assistance in Section 9.1.3 in a progress note.

9.2. The Contractor may discontinue services for a client who does not pay their share of the allowable fee(s), only after working with the client as described in Section 9.1.3.

9.3. The Contractor shall provide clients with copies of their individual financial accounts, upon the clients' request.

10. Service Delivery Activities and Requirements

10.1. The Contractor shall assess all clients for risk of self-harm at all phases of treatment, such as at initial contact, during screening, intake, admission, on-going treatment services and at discharge based on policies and process approved by the Department within thirty (30) days from the contract effective date.

10.2. The Contractor shall assess all clients for withdrawal risk based on ASAM (2013) standards at all phases of treatment, such as at initial contact, during screening, intake, admission, on-going treatment services and stabilize all clients based on ASAM (2013) guidance and shall:

10.2.1. Provide stabilization services when a client's level of risk indicates a service with an ASAM Level of Care that can be provided under this Contract; If a client's risk level indicates a service with an ASAM Level of Care that can be provided under this contract, then the Contractor shall integrate withdrawal management into the client's treatment plan and provide on-going assessment of withdrawal risk to ensure that withdrawal is managed safely.

10.2.2. Refer clients to a facility where the services can be provided when a client's risk indicates a service with an ASAM Level of Care that is higher than can be provided under this Contract; Coordinate with the withdrawal management services provider to admit the client to an appropriate service once the client's withdrawal risk has reached a level that can be provided under this contract. and

10.3. The Contractor shall complete treatment plans for all clients based on clinical evaluation data within 3 days of the clinical evaluation (defined in Section 7.1.6) and must address all ASAM (2013) domains and shall:

10.3.1. Be updated based on any changes in any American Society of Addiction Medicine Criteria (ASAM) domain and no less frequently than every 4 sessions or every 4 weeks, whichever is less frequent;

10.3.1. Have Treatment plan goals, objectives, and interventions written in terms that are specific, measurable, attainable, realistic and timely;

10.3.2. Evidence the client's involvement in identifying, developing, and prioritizing goals, objectives, and interventions.

10.4. The Contractor shall provide case management to clients that includes, at a minimum, coordination or care with Medication Assisted Treatment, physical, behavioral health, and peer recovery support providers as applicable with the client's:

10.4.1. Primary care provider and if the client does not have a primary care

provider, the Contractor will make an appropriate referral to one and coordinate care with that provider.

10.4.2. Behavioral health care provider when serving clients with co-occurring substance use and mental health disorders, and if the client does not have a mental health care provider, then the Contractor will make an appropriate referral to one and coordinate care with that provider.

10.4.3. Medication assisted treatment provider.

10.4.4. Peer recovery support provider, and if the client does not have a peer recovery support provider, the Contractor will make an appropriate referral to one and coordinate care with that provider. Such coordination will include actively coordinating with local recovery community organizations (where available) to bring peer recovery support providers into the treatment setting to meet with clients to describe available services and engage clients in peer recovery support services as applicable.

10.5. The Contractor shall submit for Department approval within thirty (30) days from the contract effective date, the policies and procedures for coordination of care described in in Section 10.4

10.6. The Contractor will make continuing care, transfer, and discharge for all Services in Section 4. The Contractor shall decisions based on ASAM (2013) criteria and complete continuing of care, transfer and discharge plans that address all ASAM (2013) domains as follows:

10.6.1. Begin the process of discharge/transfer planning at the time of the client's intake to the program.

10.6.2. Review the 3 criteria for continuing services or the 4 criteria for transfer/discharge, when addressing continuing care or discharge/transfer that include:

10.6.2.1. Continuing Service Criteria A: The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals; or

10.6.2.2. Continuing Service Criteria B: The patient is not yet making progress, but has the capacity to resolve his or her problems. He/she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his/her treatment goals; and /or

10.6.2.3. Continuing Service Criteria C: New problems have been identified that are appropriately treated at the present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay in the current level of care. The level of care which the patient is receiving treatment is therefore the least intensive level at which the patient's problems can be addressed effectively

10.6.2.4. Transfer/Discharge Criteria A: The Patient has achieved the goals articulated in the individualized treatment plan, thus resolving the problem(s) that justified admission to the present level of care. Continuing the chronic disease management of the patient's condition at a less intensive level of care is indicated; or

10.6.2.5. Transfer/Discharge Criteria B: The patient has been unable to resolve the problem(s) that justified the admission to the present level of care, despite amendments to the treatment plan. The patient is determined to have achieved the maximum possible benefit from engagement in services at the current level of care. Treatment at another level of care (more or less intensive) in the same type of services, or discharge from treatment, is therefore indicated; or

10.6.2.6. Transfer/Discharge Criteria C: The patient has demonstrated a lack of capacity due to diagnostic or co-occurring conditions that limit his or her ability to resolve his or her problem(s). Treatment at a qualitatively different level of care or type of service, or discharge from treatment, is therefore indicated; or

10.6.2.7. Transfer/Discharge Criteria D: The patient has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively at a more intensive level of care.

10.6.3. The Contractor shall maintain clear documentation that explains why continued services are necessary for Recovery Support Services.

10.7. The Contractor will ensure educational information is provided to clients in all programs on HCV/HIV/TB & STD's as evidenced by inclusion in programming.

10.8. The Contractor shall deliver services using evidence based practices as demonstrated by meeting one of the following criteria in Section 2.6.

10.9. The Contractor shall deliver services in this Contract in accordance with:

10.9.1. The ASAM Criteria (2013). The ASAM Criteria (2013) can be purchased

online through the ASAM website at: http://www.asamcriteria.org/

10.9.2. The Substance Abuse Mental Health Services Administration (SAMHSA) Treatment Improvement Protocols (TIPs) available at http://store.samhsa.gov/list/series?name=TIP-Series-Treatment-Improvement-Protocols-TIPS-

10.9.3. The SAMHSA Technical Assistance Publications (TAPs) available at http://store.samhsa.gov/list/series?name=Technical-Assistance-Publications-TAPs-&pageNumber=1

10.9.4. The Requirements in Exhibit K.

11. Continuous Recovery Monitoring

11.1. The Contractor shall provide Continuous Recovery Monitoring services to clients by providing on-going contact with a client following discharge from the program as follows:

11.1.1. Attempt to contact each client a minimum of three (3) times over the course of one week by telephone at a reasonable time when the client would normally be available.

11.1.2. Provide to the Department within 30 days of the contract effective date, the policies and procedures in place for at least one completed biweekly contact as in Sections 11.1.3 through 11.1.8, by telephone or face to face, with the client following discharge. Contact clients at least bi-weekly and no less frequently than:

11.1.2.1. 3 months post-discharge which is defined as 60 to 120 days from the last treatment service.

11.1.2.2. 6 months post-discharge which is defined as 150 to 210 days from the last treatment service.

11.1.2.3. 12 months post-discharge which is defined as 330 to 390 days from the last treatment service.

11.1.3. Inquire on the status of each client's recovery.

11.1.4. Identify any client needs.

11.1.5. Assist the client with addressing the needs identified in Section 11.1.4.

11.1.6. Provide early intervention to clients who have relapsed or whose recovery is at risk, as identified in Section 11.1.4, and record the same.

11.1.7. Include assessment of the National Outcomes Measures (NOMS) based client outcomes in WITS.

11.1.8. Complete the Client Follow-Up in WITS within 3 days of each completed contact.

11.2. The Contractor shall comply with performance of Exhibit A, Section 11.1.2, as follows:

11.2.1. Twenty-five percent (25%) of discharged clients shall be contacted three (3) months after discharge.

11.2.2. Ten percent (10%) of discharged clients shall be contacted (6) months after discharge.

11.2.3. Five percent (5%) of discharged clients shall be contacted twelve (12) months after discharge.

12. Tobacco Cessation

12.1. The Contractor shall offer tobacco cessation tools and education to all eligible clients receiving services in this contract as follows:

12.1.1. Asses clients for motivation in stopping the use of tobacco products;

12.1.2. Offer resources such as but not limited to the Department's Tobacco Prevention & Control Program (TPCP) and the certified tobacco cessation counselors available through the QuitLine; and

12.1.3. Shall not use tobacco use, in and of itself, as grounds for discharging clients from services being provided under this contract.

13. Tobacco Free Environment

13.1. The Contractor shall have policies and procedures that create a tobacco-free environment. At a minimum these policies shall:

13.1.1. Include the smoking of any tobacco product, the use of oral tobacco products or "spit" tobacco, and the use of electronic devices;

13.1.2. Apply to employees, clients and employee or client visitors;

13.1.3. Prohibit the use of tobacco products within the contractor's facilities at any time.

13.1.4. Prohibit the use of tobacco in any contractor owned vehicle.

13.1.5. Include whether or not use of tobacco products is prohibited outside of the facility on the grounds.

13.1.6. If use of tobacco products is allowed outside of the facility on the grounds:

13.1.6.1. There shall be a designated smoking area(s) which is located at least 20 feet from the main entrance.

13.1.6.2. All materials used for smoking in this area, including cigarette butts and matches, will be extinguished and disposed of in appropriate containers.

13.1.6.3. Contractors will ensure periodic cleanup of the designated smoking area.

13.1.6.4. If the designated smoking area is not properly maintained, it can be eliminated at the discretion of the contractor.

13.1.7. Prohibit tobacco use in any company vehicle.

13.1.8. Prohibit tobacco use in personal vehicles when transporting people on authorized business.

13.1.9. Post the tobacco free environment policy in the contractor's facilities and vehicles and included in employee, client, and visitor orientation.

14. Resiliency and Recovery Oriented System of Care (RROSC)

14.1. The Contractor shall engage in and promote a Resiliency and Recovery Oriented System of Care (RROSC) at a minimum:

14.1.1. Provide families and communities with education around Substance Use Disorders Treatment and Recovery Support Services;

14.1.2. Work with the Department's regional public health networks in order to reduce stigma associated with substance misuse and increase collaboration between prevention, treatment, and community supports.

15. Service Management and Monitoring

15.1. The Contractor shall maintain a consistent service capacity for Substance Use Disorder Treatment and Recovery Support Services statewide by:

15.1.1. Monitoring its individual capacity to consistently and evenly deliver these services; and

15.1.2. Monitoring and managing the utilization levels of care and service array required under this contract throughout the contract period.

15.1.3. No less than monthly, the Contractor shall monitor the percentage of the contract funding expended relative to the percentage of the contract period that has elapsed. If there is a difference of more than 10% between expended funding and elapsed time on the contract the contractor shall notify the Department within 5 days and submit a plan for correcting the discrepancy within 10 days of notifying the Department.

15.1.4. Beginning on July 1, 2016 and continuing every three months thereafter, the Department shall review the Contractor's utilization as described in Section 15.1.3 above. If the Contractor's expended funding is more than 25% below the elapsed time on the contract, the Department may amend the contract to reduce the overall price limitation.

16. Service Area

16.1. The Contractor will provide services described in this Scope of Work to any

eligible client, regardless of where the client lives or works in New Hampshire.

17. Residential Facilities License

17.1. A residential facilities license from the Department's Bureau of Health Facilities Administration is not applicable for this Contract.

18. Staffing Requirements

18.1. The Contractor shall meet the minimum staffing requirements as follows:

18.1.1. At least one Masters Licensed Alcohol and Drug Counselor (MLADC) or Licensed Alcohol and Drug Counselor (LADC) who also holds the Licensed Clinical Supervisor (LCS) credential;

18.1.2. At least one MLADC or Licensed Alcohol and Drug Counselor (LADC) for every two unlicensed counselors providing clinical services;

18.1.3. A sufficient number of:

18.1.3.1. MLADCs to adequately provide for staff clinical supervision; and/or

18.1.3.2. A sufficient number of LADCs with the LCS (Licensed Clinical Supervisor) credential to adequately provide for staff clinical supervision; and

18.1.3.3. At least one Certified Recovery Support Worker (CRSW) for every 50 clients or portion thereof.

18.2. The Contractor shall utilize CRSWs to provide treatment services within their scope of practice as defined by New Hampshire Administrative Rule Title XXX, Chapter 330-C, Section 13.

18.3. Unlicensed staff providing clinical or recovery support services must hold a CRSW within 6 months of hire or effective date of this contract, whichever is later.

18.4. Have policies and procedures related to student interns to address minimum coursework, experience and core competencies for those interns having direct contact with individuals served by this contract, including but not limited to:

18.4.1. The Contractor shall base intern responsibilities and caseloads on student learning needs and school requirements and shall not utilize interns as adjunct staff to meet the staffing needs of the Contractor.

18.4.2. Have student interns complete an approved ethics course prior to beginning their internship.

18.4.3. Provide ongoing clinical supervision that includes:

18.4.4. Weekly discussion of cases with suggestions for resources or therapeutic approaches, co-therapy, and periodic assessment of

progress;

18.4.5. Group supervision to help optimize the learning experience, when enough candidates are under supervision;

18.4.6. Content that covers the:

18.4.6.1. Knowledge, skills, values, and ethics with specific application to the practice issues faced by the supervisee, and that covers;

18.4.6.2. The core functions as described in the Twelve Core Functions of Alcohol and Drug Counseling, available at http://store.samhsa.gov/product/TAP-21-Addiction-Counseling-Competencies/SMA15-4171; and

18.4.6.3. The standards of practice and ethical conduct, with particular emphasis given to the counselor's role and appropriate responsibilities, professional boundaries, and power dynamics.

18.5. The Contractor shall notify the Department, in writing of changes in key personnel and provide, within five (5) business days to the Department, updated resumes that clearly indicate the staff member is employed by the Contractor. Key personnel are those staff for whom at least 10% of their work time is spent providing alcohol or other drug abuse treatment services.

18.6. The Contractor shall notify the Department in writing within one month of hire when a new administrator or coordinator or any staff person essential to carrying out this scope of services is hired to work in the program. The Contractor shall provide a copy of the resume of the employee, which clearly indicates the staff member is employed by the Contractor, with the notification.

18.7. The Contractor shall notify the Department in writing and submit a corrective action plan for Department approval within 14 days, when staffing does not meet the requirements defined in 18.1 through 18.4.

18.8. The Contractor shall provide in-service training to all staff involved in client care within 15 days of the contract effective date or the staff person's start date, if after the contract effective date, and at least every 90 days thereafter on the following:

18.8.1. The contract requirements;

18.8.2. Requirements in Exhibit K;

18.8.3. SAMHSA Substance Abuse Prevention and Treatment Block Grant requirements relative to treatment services using a checklist provided by the Department; and

18.8.4. All other relevant policies and procedures provided by the Department.

18.9. The Contractor shall provide in-service training or ensure attendance at an approved training by the Department to clinical staff on HCV/HIV/TB & STD's annually. The contractor shall provide the Department with a list of staff attending an in-service training or Certificates of Attendance.

18.10. The Contractor shall provide suitable office, treatment, and meeting space that complies with all fire, health, and safety codes and is handicapped and wheelchair accessible.

19. Web Information Technology System

19.1. The Contractor shall use the Web Information Technology System to record all encounter notes such as client activity and client contact within (3) days following the activity or contact including but not limited to: screening, fee determination, admission, billing, disenrollment, and discharge data.

19.2. The Contractor agrees that all encounter notes will include a record of the clinical content of the session. Encounter notes will be oriented track to client's progress with specific treatment goals.

20. Quality Assurance

20.1. The Contractor shall participate in all quality improvement activities requested by the Department such as, but not limited to:

20.1.1. Submission of monthly, web based contract compliance reports no later than the 10th day of the month following the reporting month;

20.1.2. Participation in electronic and in-person client record reviews;

20.1.3. Participation in site visits;

20.1.4. Reporting on National Outcome Measures (NOMs) data in WITS for:

20.1.4.1. 100% of all clients at admission;

20.1.4.2. 100% of all clients who are discharged because they have completed treatment or transferred to another program;

20.1.4.3. 50% of all clients who are discharged for reasons other than those specified above in Section 20.1.4.2;

20.1.4.4. 25% of all clients who are 3 months post-discharge as defined in Section 11.1.2.1;

20.1.4.5. 10% of all clients who are 6 months post-discharge as defined in Section 11.1.2.2;

20.1.4.6. 5% of all clients who are 12 months post-discharge as defined in Section 11.1.2.3;

20.1.4.7. The above NOMs reporting requirements are minimum requirements and the Contractor shall attempt to achieve

greater reporting results when possible.

20.1.5. Participation in training and technical assistance activities as directed by the Department, including but not limited to the ASAM Community of Practice developed by the Center for Excellence (the Department's Drug and Alcohol Services Technical Assistance Contractor).

21. Performance Incentives

21.1. The Contractor agrees that up to six (6) percent of the contract's maximum price limitation in Box 1.8 of the General Provision, Form P-37 will be reserved by the Department for performance incentives, except when there is a priority to pay for services. The Contractor agrees to the Department using all or some of the reserved funding to continue to pay for services when the Contractor has been reimbursed for at least 94% of the contract's price limitation for services.

21.1.1. The Contractor is eligible for incentive payments when successfully meeting the performance criteria in Section 21.1.2 and when there is available funding as in Section 21.1 at the time the Contractor meets the performance criteria.

21.1.2. The Contractor's performance criteria and incentive payments are as follows:

Performance Criteria	Incentive Payment
Access to Services: for each client who screens eligible for services and starts receiving services, other than evaluation, whether for the identified service for the ASAM Level of Care or interim services, within 10 business days following the eligibility screening.	The Contractor will receive an incentive payment of $75.00
Completion: for each client who is discharged from the program because they have completed treatment or transferred to another treatment provider as recorded in the Discharge Type field of the WITS Discharge Module.	The Contractor will receive an incentive payment of $75.00
Client Outcomes: for each client who was discharged from the program and meets at least 3 of the Outcome Criteria (in Section 21.1.2.1) in the 3rd and/or 6th month post-discharge, as evidenced by the WITS Follow-Up Module.	The Contractor will receive an incentive payment of $50.00
Client Outcomes: for each client who was discharged from the program and meets at least 3 of the Outcome	The Contractor will receive an incentive payment of

Performance Criteria	Incentive Payment
Criteria (below in Section 12.1.2.1) in the 12th month post-discharge, as evidenced by the WITS Follow-Up Module.	$100.00

21.1.2.1. The Contractor agrees to the post discharge outcome criteria as follows:

1. Abstinence: The client reports reduced or no substance use in the past 30 days prior to the contact.
2. Employment/Education: The client reports increased or retained employment or the client reports returning to or staying in school at the time of contact.
3. Crime and Criminal Justice: The client reports no arrests in the past 30 days prior to contact.
4. Stability in Housing: The client reports being in stable housing defined as not homeless or at risk of being homeless, at the time of contact.
5. Social Connectedness: The client reports engagement in Recovery Support Services, Care Coordination, and/or Community Based Support Groups in the past 30 days prior to contact.

21.1.2.2. The Contractor agrees that Performance Incentives will be calculated and paid on a monthly basis for clients meeting criteria in the previous month.

21.1.2.3. The Contractor may submit screening disposition data for all clients, regardless of payer source, at 6 months and 12 months from the contract effective date.

1. The Contractor may receive $1,000 for each submission (if funding is available in the contract at the time the Contractor submits the data, with priority of funding being for services). Screening disposition data must include:
   a. Total number of clients screened for services
   b. Number of client screened appropriate for services
   c. Number of clients engaging in services who's payer was:
      i. This contract
      ii. New Hampshire Health Protection Plan
      iii. New Hampshire Medicaid

iv. Medicare

v. Private Insurance

vi. Self-Pay

22. Liquidated Damages

22.1. The Contractor and the Department agree that the Web Information Technology System (WITS) shall be the source of record with data polls beginning September 1, 2016 and every 5 months thereafter.

22.2. The Contractor and the Department agree that it will be extremely impracticable and difficult to determine actual damages that the Department will sustain in the event that the Contractor fails to maintain the required performance standards in Section 11.2, throughout the life of the contract. Any breach by the Contractor will delay and disrupt the Department's operations and obligations and lead to significant damages. Therefore, the parties agree that the liquidated damages as specified in the sections below are reasonable.

22.3. Assessment of liquidated damages shall be in addition to, not in lieu of, such other remedies as may be available to the Department. Except and to the extent expressly provided herein, the Department shall be entitled to recover liquidated damages cumulatively under each section applicable to any given incident.

22.4. The Department shall make all assessments of liquidated damages. Should the Department determine that liquidated damages may, or will be assessed; the Department shall notify the Contractor as specified in Section 23, Notifications and Remedies for Liquidated Damages, below.

22.5. The Contractor shall submit a written Corrective Action Plan to the Department within five (5) business days of receiving notification as specified in Section 23, Notifications and Remedies for Liquidated Damages., for review and approval prior to implementation of the corrective action plan.

22.6. The Contractor agrees that as determined by the Department, failure to provide services that meet the performance standards in Section 11.2 shall result in in liquidated damages as specified in Section 23, Notifications and Remedies for Liquidated Damages. The Department's decision to assess liquidated damages must be reasonable, based in fact and made in good faith.

22.7. The remedies specified in Section 23, Notifications and Remedies for Liquidated Damages, shall apply until the failure is cured or resulting dispute is resolved in the Contractor's favor.

22.8. Liquidated damages in the amount of $2,500 for failure to meet all three of the performance measures in Section 11.2, except for Section 11.2.1 the liquidated

damage shall be assessed when the percentage falls below 15%, at the time specified in Section 22.1.

22.9. The Department will deduct the amount of liquidated damages being assessed from the amount the Department owes on the monthly billing submitted to the Department after the assessment of liquidated damages.

22.10. The amount of liquidated damages assessed by the Department to the Contractor shall not exceed the price limitation in Form P-37, General Provisions, block 1.8, Price Limitation.

23. Notifications and Remedies for Liquidated Damages.

23.1. Prior to the imposition of liquidated damages or any other remedies under this Contract, including termination for breach, the Department shall issue written notice of remedies that shall include, as applicable:

23.1.1. A citation to the Contract provision violated.

23.1.2. The remedies to be applied and the date the remedies shall be imposed.

23.1.3. The basis for the Department's determination that the remedies shall be imposed.

23.1.4. A request for a Corrective Action Plan.

23.1.5. The timeframe and procedure for the Contractor to dispute the Department's determination. The Contractor's dispute of liquidated damages or remedies shall not stay the effective date of the proposed liquidated damages or remedies.

23.1.6. If the failure is not resolved within the cure period, liquidated damages may be imposed retroactively to the date of failure to perform and continue until the failure is cured or any resulting dispute is resolved in the Contractor's favor.

23.2. In connection with any action taken or decision made by the Department with respect to this Contract, within ninety (90) days following the action or decisions, the Contractor may protest such action or decision by the delivery of a notice of protest to the Department and by which the Contractor may protest said action or decision and/or request an informal hearing with the Director of the Bureau of Drug and Alcohol Services.

23.2.1. The Contractor shall provide the Department with an explanation of its position protesting the Department's action or decision.

23.2.2. The Director shall determine a time that is mutually agreeable to the parties during which they may present their views on the disputed issues. It is understood that the presentation and discussion of the

disputed issues will be informal in nature.

23.2.3. The Director shall provide written notice of the time, format and location of the presentation.

23.2.4. At the conclusion of the presentations, the Director shall consider all evidence and shall render a written recommendation as soon as practicable, but in no event more than thirty (30) days after the conclusion of the presentation.

23.2.5. The Director may appoint a designee to hear and determine the matter.

24. State and Federal Requirements

24.1. If there is any error, omission, or conflict in the requirements listed below, the applicable Federal, State, and Local regulations, rules and requirements shall control. The requirements specified below are provided herein to increase the Contractor's compliance.

24.2. The Contractor agrees to the following state and/or federal requirements for Program requirements for specialty treatment for pregnant and parenting women:

24.2.1. The program treats the family as a unit and, therefore, admits both women and their children into treatment, if appropriate.

24.2.2. The program treats the family as a unit and, therefore, admits both women and their children into treatment, if appropriate.

24.2.3. The program provides or arranges for primary medical care for women who are receiving substance abuse services, including prenatal care.

24.2.4. The program provides or arranges for child care with the women are receiving services.

24.2.5. The program provides or arranges for primary pediatric care for the women's children, including immunizations.

24.2.6. The program provides or arranges for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting.

24.2.7. The program provides or arranges for therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.

24.2.8. The program provides or arranges for sufficient case management and transportation services to ensure that the women and their children have access to the services described above.

24.2.9. Arrange for means activities to assist the client in finding and engaging in a service, which may include, but is not limited to helping the client to locate an appropriate provider, referring clients to the needed service provider, setting up appointments for clients with those providers, and

assisting the client with attending appointments with the service provider.

24.3. The Contractor agrees to the following state and federal requirements for all programs in this Contract as follows:

24.3.1. Within 7 days of reaching 90% of capacity, the program notifies the state that 90% capacity has been reached.

24.3.2. The program admits each individual who requests and is in need of treatment for intravenous drug abuse not later than:

24.3.1.1. 14 days after making the request; or

24.3.1.2. 120 days if the program has no capacity to admit the individual on the date of the request and, within 48 hours after the request, the program makes interim services available until the individual is admitted to a substance abuse treatment program

24.3.2. The program offers interim services that include, at a minimum, the following:

24.3.2.1. Counseling and education about HIV and Tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur

24.3.2.2. Referral for HIV or TB treatment services, if necessary

24.3.2.3. Individual and/or group counseling on the effects of alcohol and other drug use on the fetus for pregnant women and referrals for prenatal care for pregnant women

24.3.3. The program has established a waiting list that includes a unique patient identifier for each injecting drug abuser seeking treatment, including patients receiving interim services while awaiting admission.

24.3.4. The program has a mechanism that enables it to:

24.3.4.1. Maintain contact with individuals awaiting admission

24.3.4.2. Admit or transfer waiting list clients at the earliest possible time to an appropriate treatment program within a service area that is reasonable to the client.

24.3.4.3. The program takes clients awaiting treatment off the waiting list only when one of the following conditions exist:

1. Such persons cannot be located for admission into treatment or
2. Such persons refuse treatment

24.3.5. The program carries out activities to encourage individuals in need of

treatment services to undergo treatment by using scientifically sound outreach models such as those outlined below or, if no such models are applicable to the local situation, another approach which can reasonably be expected to be an effective outreach method.

24.3.6. The program has procedures for:

24.3.6.1. Selecting, training, and supervising outreach workers.

24.3.6.2. Contacting, communicating, and following up with high-risk substance abusers, their associates, and neighborhood residents within the constraints of Federal and State confidentiality requirements.

24.3.6.3. Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV.

24.3.6.4. Recommending steps that can be taken to ensure that HIV transmission does not occur.

24.3.7. The program directly, or through arrangements with other public or non-profit private entities, routinely makes available the following TB services to each individual receiving treatment for substance abuse:

24.3.7.1. Counseling the individual with respect to TB.

24.3.7.2. Testing to determine whether the individual has been infected with mycobacteria TB to determine the appropriate form of treatment for the individual.

24.3.7.3. Providing for or referring the individuals infected by mycobacteria TB appropriate medical evaluation and treatment.

24.3.8. For clients denied admission to the program on the basis of lack of capacity, the program refers such clients to other providers of TB services.

24.3.9. The program has implemented the infection control procedures that are consistent with those established by the Department to prevent the transmission of TB and that address the following:

24.3.9.1. Screening patients and identification of those individuals who are at high risk of becoming infected.

24.3.9.2. Meeting all State reporting requirements while adhering to Federal and State confidentiality requirements, including 42 CFR part 2.

24.3.9.3. Case management activities to ensure that individuals receive

such services.

24.3.9.4. The program reports all individuals with active TB as required by State law and in accordance with Federal and State confidentiality requirements, including 42 CFR part 2.

24.3.10. The program gives preference in admission to pregnant women who seek or are referred for and would benefit from Block Grant funded treatment services. Further, the program gives preference to clients in the following order:

24.3.10.1. To pregnant and injecting drug users first.

24.3.10.2. To other pregnant substance users second.

24.3.10.3. To other injecting drug users third.

24.3.10.4. To all other individuals fourth.

24.3.11. The program refers all pregnant women to the State when the program has insufficient capacity to provide services to any such pregnant women who seek the services of the program.

24.3.12. The program makes available interim services within 48 hours to pregnant women who cannot be admitted because of lack of capacity.

24.3.13. The program makes continuing education in treatment services available to employees who provide the services.

24.3.14. The program has in effect a system to protect patient records from inappropriate disclosure, and the system:

24.3.14.1. Is in compliance with all Federal and State confidentiality requirements, including 42 CFR part 2.

24.3.14.2. Includes provisions for employee education on the confidentiality requirements and the fact that disciplinary action may occur upon inappropriate disclosure.

24.3.15. The program does not expend SAPT Block Grant funds to provide inpatient hospital substance abuse services, except in cases when each of the following conditions is met:

24.3.15.1. The individual cannot be effectively treated in a community-based, non-hospital, residential program.

24.3.15.2. The daily rate of payment provided to the hospital for providing the services does not exceed the comparable daily rate provided by a community-based, non-hospital, residential program.

24.3.15.3. A physician makes a determination that the following

conditions have been met:

1. The primary diagnosis of the individual is substance abuse and the physician certifies that fact.
2. The individual cannot be safely treated in a community-based, non-hospital, residential program.
3. The service can be reasonably expected to improve the person's condition or level of functioning.
4. The hospital-based substance abuse program follows national standards of substance abuse professional practice.
5. The service is provided only to the extent that it is medically necessary (e.g., only for those days that the patient cannot be safely treated in community-based, non-hospital, residential program.)

24.3.16. The program does not expend Substance Abuse Prevention and Treatment (SAPT) Block Grant funds to purchase or improve land; purchase, construct, or permanently improve (other than minor remodeling) any building or other facility; or purchase major medical equipment.

24.3.17. The program does not expend SAPT Block Grant funds to satisfy and requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.

24.3.18. The program does not expend SAPT Block Grant funds to provide financial assistance to any entity other than a public or nonprofit private entity.

24.3.19. The program does not expend SAPT Block Grant funds to make payments to intended recipients of health services.

24.3.20. The program does not expend SAPT Block Grant funds to provide individuals with hypodermic needles or syringes.

24.3.21. The program does not expend SAPT Block Grant funds to provide treatment services in penal or corrections institutions of the State.

24.3.22. The program uses the Block Grant as the "payment of last resort" for services for pregnant women and women with dependent children, TB services, and HIV services and, therefore, makes every reasonable effort to do the following:

24.3.22.1. Collect reimbursement for the costs of providing such services to persons entitled to insurance benefits under the Social Security Act, including programs under title XVIII and

title XIX; any State compensation program, any other public assistance program for medical expenses, any grant program, any private health insurance, or any other benefit program.

24.3.22.2. Secure from patients of clients payments for services in accordance with their ability to pay.

24.4. The Contractor shall comply with all relevant state and federal laws such as but not limited to:

24.4.1. The Contractor shall, upon the direction of the State, provide court-ordered evaluation and a sliding fee scale (in Exhibit B) shall apply and submission of the court-ordered evaluation and shall, upon the direction of the State, offer treatment to those individuals.

24.4.2. The Contractor shall comply with the legal requirements governing human subject's research when considering research, including research conducted by student interns, using individuals served by this contract as subjects. Contractors must inform and receive the Department's approval prior to initiating any research involving subjects or participants related to this contract. The Department reserves the right, at its sole discretion, to reject any such human subject research requests.

24.4.3. Contractors shall comply with the Department's Sentinel Event Reporting Policy.

Method and Conditions Precedent to Payment

1. The State shall pay the Contractor an amount not to exceed the Price Limitation, Block 1.8, of the General Provisions, for the services provided by the Contractor pursuant to Exhibit A.

2. This Agreement is funded by:
   2.1. New Hampshire General Funds;
   2.2. Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment Funds;
   2.3. Federal Funds from the United States Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration, Substance Abuse Prevention and Treatment Block Grant (CFDA #93.959); and
   2.4. The Contractor agrees to provide the services in Exhibit A, Scope of Services in compliance with funding requirements.

3. The Contractor agrees to be reimbursed for services listed in Exhibit B-1 on a fee for service basis, unless otherwise stated. The Contractor agrees the fees for services are all-inclusive rates to deliver the services and to meet the requirements in Exhibit A.

4. Method for Charging Services under this Contract
   4.1. The Contractor agrees to:

      4.1.1. Directly bill and receive payments for services provided under this contract from public and private insurance plans, the clients, and the Department;
      4.1.2. Assuring a billing and payment system that enables expedited processing to the greatest degree possible so that a client's admittance into the program is not unduly delayed, and overpayments are immediately refunded.
      4.1.3. Maintaining an accurate accounting and records for all services billed, payments received and overpayments (if any) refunded.

   4.2. The Contractor agrees to determine and charge for services provided to an eligible client under this contract, as follows:

      4.2.1. The Contractor shall charge up to the Contract Rate, in Exhibit B-1, by first charging the client's private insurance when the insurers' rates are at or lower than the Contract Rate.
      4.2.2. The Contractor shall charge the client according to a Sliding fee scale, in Section 9, when the Contractor determines or anticipates that the private insurer will not remit payment for the full amount of the Contract Rate in Exhibit B-1.
      4.2.3. If, after the Contractor charges the client's insurer (if applicable) and the client, any portion of the Contract Rate remains unpaid, the Contractor shall charge the

Department the balance (the Contract Rate less the private insurer and the client cost shares).

4.3. The Contractor agrees the amount charged to the client shall not exceed the Contract Rate in Exhibit B-1 multiplied by the corresponding percentage stated in Section 9 Sliding fee scale for the client's applicable income level.

4.4. The Contractor shall not charge the combination of the public or private insurer, the client and the Department an amount greater than the Contract Rate in Exhibit B-1.

4.5. In the event of an overpayment (wherein the combination of all payments received by the Contractor) for a given service exceeds the Contract Rate stated in Exhibit B-1, the Contractor shall refund the parties in the reverse order, unless the overpayment was due to insurer, client or Departmental error. In instances of payer error, the Contractor shall refund the party who erred, and adjust the charges to the other parties, according to a correct application of the Sliding Fee Schedule.

5. The Contractor shall submit billing through the Website Information Technology System (WITS) for services listed in Exhibit B-1, except for Integrated Medication Assisted (See Section 6) and Enhanced Services (See Section 7) as follows:

5.1. Enter encounter note(s) into WITS no later than three (3) days after the date the service was provided to the client

5.2. Review the encounter notes no later than 20 days following the last day of the billing month, and notify the Department that encounter notes are ready for review.

5.3. Correct errors, if any, in the encounter notes as identified by the Department no later than 7 days after being notified of the errors and notify the Department the notes have been corrected and are ready for review.

5.4. Batch and transmit the encounter notes upon Department approval for the billing month.

5.4.1. Submit separate batches for each billing month.

5.5. Agrees that encounter notes submitted for review after sixty (60) days of the last day of the billing month may be subject to non-payment.

6. Payment for Medication Assisted Treatment (MAT)shall be as follows:

6.1. The Contractor agrees to invoice the Department separately from the Web Information Technology System (WITS) for Integrated Medication Assisted Treatment Services for Staff Time, Medication, and Physician Time.

6.2. Staff Time: Staff Time is for non-medical staff time relative to the MAT program that is not billable as another service under this contract, such as consultation with a prescribing physician. The Contractor shall be reimbursed according to the contract rate, unit type and service limit in Exhibit B-1.

6.3. Medication Contract Rate, Unit Type and Service Limit:

6.3.1. The Contractor will be reimbursed for the Medication Assisted Treatment medication based on the Contractor's usual and customary charges according to Revised Statues Annotated (RSA) 126-A:3 III. (b),

6.3.2. The Contractor will be reimbursed for Medication Assisted Treatment with Methadone or Buprenorphine in an Opiate Treatment Program (OTP) certified per New Hampshire Administrative Rule He-A 304 as follows: The Contractor will be reimbursed for Methadone or Buprenorphine based on the Medicaid rate, up to 7 days per week. The code for Methadone in an OTP is H0020, and the code for buprenorphine in an OTP is H0033. The Contractor agrees to invoice the Department separately from the Web Information Technology System (WITS) for Medication Assisted Treatment Services.

6.3.3. The Contractor will be reimbursed for up to 3 doses per client per day.

6.4. Physician Time: Physician Time is the time spent by a physician or other medical professional to provide Medication Assisted Treatment Services, including but not limited to assessing the client's appropriateness for a medication, prescribing and/or administering a medication, and monitoring the client's response to a medication. The Contractor shall be reimbursed according to the contract rate, unit type and service limit in Exhibit B-1.

6.5. The invoice at a minimum shall include:

6.5.1. For non-medical staff time:

6.5.1.1. A clear description of each expense including WITS Client ID #(s) when applicable;

6.5.1.2. The amount of each expense; and

6.5.1.3. The total of all expenses for the billing period in a Department defined invoice.

6.5.2. For client medications:

6.5.2.1. WITS Client ID #;

6.5.2.2. Period for which prescription is intended;

6.5.2.3. Name and dosage of the medication;

6.5.2.4. Associated Medicaid Code;

6.5.2.5. Charge for the medication.

6.5.2.6. Client cost share for the service; and

6.5.2.7. Amount being billed to the Department for the service.

6.5.3. For physician and other medical professional services:

6.5.3.1. WITS Client ID #;

6.5.3.2. Date of Service;

6.5.3.3. Description of service;

6.5.3.4. Associated Medicaid Code;

6.5.3.5. Charge for the service;

6.5.3.6. Client cost share for the service; and
6.5.3.7. Amount being billed to the Department for the service.

6.6. The Contractor will submit an invoice by the 20th day of each month, which identifies and requests reimbursement for authorized expenses incurred for medication assisted treatment in the prior month. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice for Contractor services provided pursuant to this Agreement. Invoices must be submitted to:

Financial Manager
Division of Community Based Care Services
Bureau of Drug and Alcohol Services
105 Pleasant Street,
Main Bldg., 3rd Floor North
Concord, NH 03301

7. Payment for Enhanced Services:
   7.1. The Department will reimburse the Contractor for Enhanced Services based on actual activities and services directly provided to the client, as defined in Exhibit A, Section 6.1.1.3
   7.2. The Contractor shall be reimbursed up to the amount in Exhibit B-1.
   7.3. The Contractor shall submit actual expenses on a Department defined invoice.
   7.4. The Contractor shall provide a clear description of each expense, the amount of each expense, and the total of all expenses for the billing period.
   7.5. The Department will reimburse on allowable expenses, in accordance with applicable state and federal laws and regulations.
   7.6. The Contractor will submit an invoice by the 20th day of each month, which identifies and requests reimbursement for authorized expenses incurred for enhanced services in the prior month. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice for Contractor services provided pursuant to this Agreement. Invoices must be submitted to:

Financial Manager
Division of Community Based Care Services
Bureau of Drug and Alcohol Services
105 Pleasant Street,
Main Bldg., 3rd Floor North
Concord, NH 03301

8. Payment for Crisis Services to Existing Clients and their Significant Others:
   8.1. The Department will reimburse the Contractor for Crisis Services as a fee for service either as individual outpatient services or individual recovery support services (non-

clinical) as defined in Exhibit A, Section 5.2 or 5.3, respectively and at the rates, unit type, and service limit in Exhibit B-1.

9. Sliding Fee Scale
   9.1. The Sliding Fee Scale shall apply to the services listed in Exhibit B-1 except Integrated Medication Assisted Treatment – Staff time that is not a direct service to a specific client(s) (See Section 6) and Enhanced Services (See Section 7) as follows:
   9.2. The Contractor will charge the client their portion of the Contract Rate (Maximum Allowed Charge) found in Exhibit B-1, based on the following sliding fee scale as follows:

      9.2.1. When the client's income is 0% to 138% of the Federal Poverty Level (FPL), the Contractor will charge the client 0% of the Contract Rate.
      9.2.2. When the client's income is 139 to 149% of the Federal Poverty Level (FPL), the Contractor will charge the client 8% of the Contract Rate.
      9.2.3. When the client's income is 150% to 199% of the Federal Poverty Level (FPL), the Contractor will charge the client 12% of the Contract Rate.
      9.2.4. When the client's income is 200% to 249% of the Federal Poverty Level (FPL), the Contractor will charge the client 25% of the Contract Rate.
      9.2.5. When the client's income is 250% to 299% of the Federal Poverty Level (FPL), the Contractor will charge the client 40% of the Contract Rate.
      9.2.6. When the client's income is 300% to 349% of the Federal Poverty Level (FPL), the Contractor will charge the client 57%% of the Contract Rate.
      9.2.7. When the client's income is 350% to 399% of the Federal Poverty Level (FPL), the Contractor will charge the client 77% of the Contract Rate.

   9.3. The Contractor shall not deny a minor child (under the age of 18) services because of the parent's unwillingness to pay the fee or the minor child's decision to receive confidential services pursuant to RSA 318-B:12-a.

10. Non Reimbursement for Services
   10.1. The State will not reimburse the Contractor for services provided through this contract when a client has or may have an alternative payer for services described in this scope of work, such as:

      10.1.1. Services covered by New Hampshire Health Protection Program for clients who are eligible for the New Hampshire Health Protection Program.
      10.1.2. Services covered by New Hampshire Medicaid for clients who are eligible for New Hampshire Medicaid.
      10.1.3. Services covered by Medicare for clients who are eligible for Medicare.
      10.1.4. Services covered by the client's private insurer(s) at a rate greater than the contract rate (in Exhibit B-1) set by the Department.

10.2. Notwithstanding Section 10.1 above, the Contractor may seek reimbursement from the State for services provided under this contract when a client needs a service that is not covered by the payers listed in Section 10.1.

11. When the contract price limitation is reached the program shall continue to operate at full capacity at no charge to the Department for the duration of the contract period.

12. Funding may not be used to replace funding for a program already funded from another source.

13. The Contractor will keep records of their activities related to Department programs and services.

14. Notwithstanding anything to the contrary herein, the Contractor agrees that funding under this agreement may be withheld, in whole or in part, in the event of non-compliance with any Federal or State law, rule or regulation applicable to the services provided, or if the said services or products have not been satisfactorily completed in accordance with the terms and conditions of this agreement.

15. Contractor will have forty-five (45) days from the end of the contract period to submit to the Department final invoices for payment. Any adjustments made to a prior invoice will need to be accompanied by supporting documentation.

16. Limitations and restrictions of federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds:
    16.1. The Contractor agrees to use the SAPT funds as the payment of last resort.
    16.2. The Contractor agrees to the following funding restrictions on SAPT Block Grant expenditures to:

        16.2.1. Make cash payments to intended recipients of substance abuse services.
        16.2.2. Expend more than the amount of Block Grant funds expended in Federal Fiscal Year 1991 for treatment services provided in penal or correctional institutions of the State.
        16.2.3. Use any federal funds provided under this contract for the purpose of conducting testing for the etiologic agent for Human Immunodeficiency Virus (HIV) unless such testing is accompanied by appropriate pre and post-test counseling.
        16.2.4. Use any federal funds provided under this contract for the purpose of conducting any form of needle exchange, free needle programs or the distribution of bleach for the cleaning of needles for intravenous drug abusers.

    16.3. The Contractor agrees to the Charitable Choice federal statutory provisions as follows:

16.3.1. Federal Charitable Choice statutory provisions ensure that religious organizations are able to equally compete for Federal substance abuse funding administered by SAMHSA, without impairing the religious character of such organizations and without diminishing the religious freedom of SAMHSA beneficiaries (see 42 USC 300x-65 and 42 CFR Part 54 and Part 54a, 45 CFR Part 96, Charitable Choice Provisions and Regulations). Charitable Choice statutory provisions of the Public Health Service Act enacted by Congress in 2000 are applicable to the SAPT Block Grant program. No funds provided directly from SAMHSA or the relevant State or local government to organizations participating in applicable programs may be expended for inherently religious activities, such as worship, religious instruction, or proselytization. If an organization conducts such activities, it must offer them separately, in time or location, from the programs or services for which it receives funds directly from SAMHSA or the relevant State or local government under any applicable program, and participation must be voluntary for the program beneficiaries.

Service and Fee Table

1. The Contractor shall be reimbursed for the Services and up to the Contract Rates in Table A below.
   a. The Contract Rates in the Table A are the maximum allowed charged used in the Methods for Charging for Services under this Contract in Exhibit B, Section 4.

Table A

Service	Contract Rate (Maximum Allowed Charge)	Unit	Service Limit
Clinical Evaluation	$250.00	Per evaluation	1 evaluation per 90 days, per client
Individual Outpatient	$20.00	15 min	$200 of combined individual & group per week, per client
Group Outpatient	$6.00	15 min	
Intensive Outpatient	$95.00	Per day and only on those days when the client attends individual and/or group counseling associated with the program.	4 days per week ($380), per client
Integrated Medication Assisted Treatment - Contractor Staff Time	$7.50	15 min.	3 hours per client per week
Integrated Medication Assisted Treatment - Physician Time	Rate Per Medicaid Physician Billing Codes: 99201 - 99205 and 99211 - 99215.	Unit Per Medicaid Physician Billing Codes: 99201 - 99205 and 99211 - 99215.	1 hour per client per week
Integrated Medication Assisted Treatment – Medication	See Exhibit B, Section 6.3	See Exhibit B, Section 6.3	See Exhibit B, Section 6.3
Continuous Recovery Monitoring - Attempted	$15.00	Per 3 attempted contacts over the course of at least 1 week	$60 of combined attempted and completed per month for the first 12 months post discharge, per client
Continuous Recovery Monitoring - Completed	$15.00	Per 1 completed contact	
Individual Recovery Support Services (Non-Clinical)	$15.00	15 min	$160 of combined individual & group per week, per client
Group Recovery Support Services (Non-Clinical)	$5.00	15 min	
Enhanced Services	Cost Reimbursement	Cost Reimbursement	Up to $51,750, and according to Section 7 of Exhibit B. This amount is inclusive of the amount in the Box 1.8 of the P-37.

SPECIAL PROVISIONS

Contractors Obligations: The Contractor covenants and agrees that all funds received by the Contractor under the Contract shall be used only as payment to the Contractor for services provided to eligible individuals and, in the furtherance of the aforesaid covenants, the Contractor hereby covenants and agrees as follows:

1. **Compliance with Federal and State Laws:** If the Contractor is permitted to determine the eligibility of individuals such eligibility determination shall be made in accordance with applicable federal and state laws, regulations, orders, guidelines, policies and procedures.

2. **Time and Manner of Determination:** Eligibility determinations shall be made on forms provided by the Department for that purpose and shall be made and remade at such times as are prescribed by the Department.

3. **Documentation:** In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

4. **Fair Hearings:** The Contractor understands that all applicants for services hereunder, as well as individuals declared ineligible have a right to a fair hearing regarding that determination. The Contractor hereby covenants and agrees that all applicants for services shall be permitted to fill out an application form and that each applicant or re-applicant shall be informed of his/her right to a fair hearing in accordance with Department regulations.

5. **Gratuities or Kickbacks:** The Contractor agrees that it is a breach of this Contract to accept or make a payment, gratuity or offer of employment on behalf of the Contractor, any Sub-Contractor or the State in order to influence the performance of the Scope of Work detailed in Exhibit A of this Contract. The State may terminate this Contract and any sub-contract or sub-agreement if it is determined that payments, gratuities or offers of employment of any kind were offered or received by any officials, officers, employees or agents of the Contractor or Sub-Contractor.

6. **Retroactive Payments:** Notwithstanding anything to the contrary contained in the Contract or in any other document, contract or understanding, it is expressly understood and agreed by the parties hereto, that no payments will be made hereunder to reimburse the Contractor for costs incurred for any purpose or for any services provided to any individual prior to the Effective Date of the Contract and no payments shall be made for expenses incurred by the Contractor for any services provided prior to the date on which the individual applies for services or (except as otherwise provided by the federal regulations) prior to a determination that the individual is eligible for such services.

7. **Conditions of Purchase:** Notwithstanding anything to the contrary contained in the Contract, nothing herein contained shall be deemed to obligate or require the Department to purchase services hereunder at a rate which reimburses the Contractor in excess of the Contractors costs, at a rate which exceeds the amounts reasonable and necessary to assure the quality of such service, or at a rate which exceeds the rate charged by the Contractor to ineligible individuals or other third party funders for such service. If at any time during the term of this Contract or after receipt of the Final Expenditure Report hereunder, the Department shall determine that the Contractor has used payments hereunder to reimburse items of expense other than such costs, or has received payment in excess of such costs or in excess of such rates charged by the Contractor to ineligible individuals or other third party funders, the Department may elect to:
   7.1. Renegotiate the rates for payment hereunder, in which event new rates shall be established;
   7.2. Deduct from any future payment to the Contractor the amount of any prior reimbursement in excess of costs;

7.3. Demand repayment of the excess payment by the Contractor in which event failure to make such repayment shall constitute an Event of Default hereunder. When the Contractor is permitted to determine the eligibility of individuals for services, the Contractor agrees to reimburse the Department for all funds paid by the Department to the Contractor for services provided to any individual who is found by the Department to be ineligible for such services at any time during the period of retention of records established herein.

RECORDS: MAINTENANCE, RETENTION, AUDIT, DISCLOSURE AND CONFIDENTIALITY:

8. **Maintenance of Records:** In addition to the eligibility records specified above, the Contractor covenants and agrees to maintain the following records during the Contract Period:
   8.1. Fiscal Records: books, records, documents and other data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor during the Contract Period, said records to be maintained in accordance with accounting procedures and practices which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.
   8.2. Statistical Records: Statistical, enrollment, attendance or visit records for each recipient of services during the Contract Period, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.
   8.3. Medical Records: Where appropriate and as prescribed by the Department regulations, the Contractor shall retain medical records on each patient/recipient of services.

9. **Audit:** Contractor shall submit an annual audit to the Department within 60 days after the close of the agency fiscal year. It is recommended that the report be prepared in accordance with the provision of Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non Profit Organizations" and the provisions of Standards for Audit of Governmental Organizations, Programs, Activities and Functions, issued by the US General Accounting Office (GAO standards) as they pertain to financial compliance audits.
   9.1. Audit and Review: During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts.
   9.2. Audit Liabilities: In addition to and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department, all payments made under the Contract to which exception has been taken or which have been disallowed because of such an exception.

10. **Confidentiality of Records:** All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be disclosed by the Contractor, provided however, that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Contract; and provided further, that the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian.

Notwithstanding anything to the contrary contained herein the covenants and conditions contained in the Paragraph shall survive the termination of the Contract for any reason whatsoever.

11. **Reports:** Fiscal and Statistical: The Contractor agrees to submit the following reports at the following times if requested by the Department.
    11.1. Interim Financial Reports: Written interim financial reports containing a detailed description of all costs and non-allowable expenses incurred by the Contractor to the date of the report and containing such other information as shall be deemed satisfactory by the Department to justify the rate of payment hereunder. Such Financial Reports shall be submitted on the form designated by the Department or deemed satisfactory by the Department.
    11.2. Final Report: A final report shall be submitted within thirty (30) days after the end of the term of this Contract. The Final Report shall be in a form satisfactory to the Department and shall contain a summary statement of progress toward goals and objectives stated in the Proposal and other information required by the Department.

12. **Completion of Services:** Disallowance of Costs: Upon the purchase by the Department of the maximum number of units provided for in the Contract and upon payment of the price limitation hereunder, the Contract and all the obligations of the parties hereunder (except such obligations as, by the terms of the Contract are to be performed after the end of the term of this Contract and/or survive the termination of the Contract) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

13. **Credits:** All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Contract shall include the following statement:
    13.1. The preparation of this (report, document etc.) was financed under a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services.

14. **Prior Approval and Copyright Ownership:** All materials (written, video, audio) produced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution or use. The DHHS will retain copyright ownership for any and all original materials produced, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports. Contractor shall not reproduce any materials produced under the contract without prior written approval from DHHS.

15. **Operation of Facilities: Compliance with Laws and Regulations:** In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Contract the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

16. **Equal Employment Opportunity Plan (EEOP):** The Contractor will provide an Equal Employment Opportunity Plan (EEOP) to the Office for Civil Rights, Office of Justice Programs (OCR), if it has received a single award of $500,000 or more. If the recipient receives $25,000 or more and has 50 or

more employees, it will maintain a current EEOP on file and submit an EEOP Certification Form to the OCR, certifying that its EEOP is on file. For recipients receiving less than $25,000, or public grantees with fewer than 50 employees, regardless of the amount of the award, the recipient will provide an EEOP Certification Form to the OCR certifying it is not required to submit or maintain an EEOP. Non-profit organizations, Indian Tribes, and medical and educational institutions are exempt from the EEOP requirement, but are required to submit a certification form to the OCR to claim the exemption. EEOP Certification Forms are available at: http://www.ojp.usdoj/about/ocr/pdfs/cert.pdf.

17. **Limited English Proficiency (LEP):** As clarified by Executive Order 13166, Improving Access to Services for persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination on the basis of limited English proficiency (LEP). To ensure compliance with the Omnibus Crime Control and Safe Streets Act of 1968 and Title VI of the Civil Rights Act of 1964, Contractors must take reasonable steps to ensure that LEP persons have meaningful access to its programs.

18. **Pilot Program for Enhancement of Contractor Employee Whistleblower Protections:** The following shall apply to all contracts that exceed the Simplified Acquisition Threshold as defined in 48 CFR 2.101 (currently, $150,000)

CONTRACTOR EMPLOYEE WHISTLEBLOWER RIGHTS AND REQUIREMENT TO INFORM EMPLOYEES OF WHISTLEBLOWER RIGHTS (SEP 2013)

(a) This contract and employees working on this contract will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239) and FAR 3.908.

(b) The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation.

(c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold.

19. **Subcontractors:** DHHS recognizes that the Contractor may choose to use subcontractors with greater expertise to perform certain health care services or functions for efficiency or convenience, but the Contractor shall retain the responsibility and accountability for the function(s). Prior to subcontracting, the Contractor shall evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor's performance is not adequate. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions.
When the Contractor delegates a function to a subcontractor, the Contractor shall do the following:
    19.1. Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function
    19.2. Have a written agreement with the subcontractor that specifies activities and reporting responsibilities and how sanctions/revocation will be managed if the subcontractor's performance is not adequate
    19.3. Monitor the subcontractor's performance on an ongoing basis

19.4. Provide to DHHS an annual schedule identifying all subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed
19.5. DHHS shall, at its discretion, review and approve all subcontracts.

If the Contractor identifies deficiencies or areas for improvement are identified, the Contractor shall take corrective action.

DEFINITIONS
As used in the Contract, the following terms shall have the following meanings:

COSTS: Shall mean those direct and indirect items of expense determined by the Department to be allowable and reimbursable in accordance with cost and accounting principles established in accordance with state and federal laws, regulations, rules and orders.

DEPARTMENT: NH Department of Health and Human Services.

FINANCIAL MANAGEMENT GUIDELINES: Shall mean that section of the Contractor Manual which is entitled "Financial Management Guidelines" and which contains the regulations governing the financial activities of contractor agencies which have contracted with the State of NH to receive funds.

PROPOSAL: If applicable, shall mean the document submitted by the Contractor on a form or forms required by the Department and containing a description of the Services to be provided to eligible individuals by the Contractor in accordance with the terms and conditions of the Contract and setting forth the total cost and sources of revenue for each service to be provided under the Contract.

UNIT: For each service that the Contractor is to provide to eligible individuals hereunder, shall mean that period of time or that specified activity determined by the Department and specified in Exhibit B of the Contract.

FEDERAL/STATE LAW: Wherever federal or state laws, regulations, rules, orders, and policies, etc. are referred to in the Contract, the said reference shall be deemed to mean all such laws, regulations, etc. as they may be amended or revised from the time to time.

CONTRACTOR MANUAL: Shall mean that document prepared by the NH Department of Administrative Services containing a compilation of all regulations promulgated pursuant to the New Hampshire Administrative Procedures Act. NH RSA Ch 541-A, for the purpose of implementing State of NH and federal regulations promulgated thereunder.

SUPPLANTING OTHER FEDERAL FUNDS: The Contractor guarantees that funds provided under this Contract will not supplant any existing federal funds available for these services.

REVISIONS TO GENERAL PROVISIONS

1. Subparagraph 4 of the General Provisions of this contract, Conditional Nature of Agreement, is replaced as follows:

   4. CONDITIONAL NATURE OF AGREEMENT.
   Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including without limitation, the continuance of payments, in whole or in part, under this Agreement are contingent upon continued appropriation or availability of funds, including any subsequent changes to the appropriation or availability of funds affected by any state or federal legislative or executive action that reduces, eliminates, or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope of Services provided in Exhibit A, Scope of Services, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of appropriated or available funds. In the event of a reduction, termination or modification of appropriated or available funds, the State shall have the right to withhold payment until such funds become available, if ever. The State shall have the right to reduce, terminate or modify services under this Agreement immediately upon giving the Contractor notice of such reduction, termination or modification. The State shall not be required to transfer funds from any other source or account into the Account(s) identified in block 1.6 of the General Provisions, Account Number, or any other account, in the event funds are reduced or unavailable.

2. Subparagraph 10 of the General Provisions of this contract, Termination, is amended by adding the following language;

   10.1 The State may terminate the Agreement at any time for any reason, at the sole discretion of the State, 30 days after giving the Contractor written notice that the State is exercising its option to terminate the Agreement.

   10.2 In the event of early termination, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement, including but not limited to, identifying the present and future needs of clients receiving services under the Agreement and establishes a process to meet those needs.

   10.3 The Contractor shall fully cooperate with the State and shall promptly provide detailed information to support the Transition Plan including, but not limited to, any information or data requested by the State related to the termination of the Agreement and Transition Plan and shall provide ongoing communication and revisions of the Transition Plan to the State as requested.

   10.4 In the event that services under the Agreement, including but not limited to clients receiving services under the Agreement are transitioned to having services delivered by another entity including contracted providers or the State, the Contractor shall provide a process for uninterrupted delivery of services in the Transition Plan.

   10.5 The Contractor shall establish a method of notifying clients and other affected individuals about the transition. The Contractor shall include the proposed communications in its Transition Plan submitted to the State as described above.

3. The Division reserves the right to renew the Contract for up to two additional years, subject to the continued availability of funds, satisfactory performance of services and approval by the Governor and Executive Council.

Contractor Initials _____

Date 4-11-16

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   - 1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted
   1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)
311 RT108 Somersworth, Strafford, NH 03878

Check ☐ if there are workplaces on file that are not identified here.

Contractor Name:

4-11-16
Date

Name:
Title: CEO

CERTIFICATION REGARDING LOBBYING

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Contractor Name:

7-11-16
Date

Name:
Title: CEO

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (I)(b) of this certification; and
    11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Contractor Name:

4-1-16
Date

Name:
Title: CEO

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

4-11-16
Date

Name:
Title: CEO

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

4-11-16
Date

Name:
Title: CEO

HEALTH INSURANCE PORTABLITY ACT
BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

(2) **Business Associate Use and Disclosure of Protected Health Information.**

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) Obligations and Activities of Business Associate.

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination for Cause

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health & Human Services	Goodwin Community Health
The State	Name of the Contractor
Katja S. Fox	Janet Laatsch
Signature of Authorized Representative	Signature of Authorized Representative
Katja S. Fox	Janet Laatsch
Name of Authorized Representative	Name of Authorized Representative
Director, Division of Behavioral Health	CEO
Title of Authorized Representative	Title of Authorized Representative
4-28-16	4-11-16
Date	Date

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.
In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.
The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:
The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

4-11-16
Date

Name: Janet Carlisch
Title: CEO

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: 780054164

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   X NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

Operational Requirements for all Programs

The contractor shall comply with the following requirements:

1. Requirements for Organizational or Program Changes.
   The contractor shall provide the department with written notice at least 30 days prior to changes in any of the following:
   1.1.1. Ownership;
   1.1.2. Physical location;
   1.1.3. Name.
   1.2. When there is a new administrator, the following shall apply:
   1.2.1. The contractor shall provide the department with immediate notice when an administrator position becomes vacant;
   1.2.2. The contractor shall notify the department in writing as soon as possible prior to a change in administrator, and immediately upon the lack of an administrator, and provide the department with the following:
   1.2.2.1. The written disclosure of the new administrator required in Section 1.2 above;
   1.2.2.2. A resume identifying the name and qualifications of the new administrator; and
   1.2.2.3. Copies of applicable licenses for the new administrator;
   1.2.3. When there is a change in the name, the contractor shall submit to the department a copy of the certificate of amendment from the New Hampshire Secretary of State, if applicable, and the effective date of the name change.
   1.2.4. When a contractor discontinues a contracted program, it shall submit to the department:
   1.2.4.1. A plan to transfer, discharge or refer all clients being served in the contracted program; and
   1.2.4.2. A plan for the security and transfer of the client's records being served in the contracted program as required by Sections 12.8 – 12.10 below and with the consent of the client.
2. Inspections.
   For the purpose of determining compliance with the contract, the contractor shall admit and allow any department representative at any time to inspect the following:
   2.1.1. The facility premises;
   2.1.2. All programs and services provided under the contract; and
   2.1.3. Any records required by the contract.
   2.2. A notice of deficiencies shall be issued when, as a result of any inspection, the department determines that the contractor is in violation of any of the contract requirements.
   2.3. If the notice identifies deficiencies to be corrected, the contractor shall submit a plan of correction in accordance within 21 working days of receiving the inspection findings.
3. Administrative Remedies.
   3.1. The department shall impose administrative remedies for violations of contract requirements, including:
   3.1.1. Requiring a contractor to submit a plan of correction (POC);
   3.1.2. Imposing a directed POC upon a contractor;
   3.1.3. Suspension of a contract; or
   3.1.4. Revocation of a contract.

3.2. When administrative remedies are imposed, the department shall provide a written notice, as applicable, which:
  3.2.1. Identifies each deficiency;
  3.2.2. Identifies the specific remedy(s) that has been proposed; and
  3.2.3. Provides the contractor with information regarding the right to a hearing in accordance with RSA 541-A and He-C 200.
3.3. A POC shall be developed and enforced in the following manner:
  3.3.1. Upon receipt of a notice of deficiencies, the contractor shall submit a written POC within 21 days of the date on the notice describing:
    3.3.1.1. How the contractor intends to correct each deficiency;
    3.3.1.2. What measures will be put in place, or what system changes will be made to ensure that the deficiency does not recur; and
    3.3.1.3. The date by which each deficiency shall be corrected which shall be no later than 90 days from the date of submission of the POC;
  3.3.2. The department shall review and accept each POC that:
    3.3.2.1. Achieves compliance with contract requirements;
    3.3.2.2. Addresses all deficiencies and deficient practices as cited in the inspection report;
    3.3.2.3. Prevents a new violation of contract requirements as a result of implementation of the POC; and
    3.3.2.4. Specifies the date upon which the deficiencies will be corrected;
3.4. If the POC is acceptable, the department shall provide written notification of acceptance of the POC;
3.5. If the POC is not acceptable, the department shall notify the contractor in writing of the reason for rejecting the POC;
3.6. The contractor shall develop and submit a revised POC within 21 days of the date of the written notification in 3.5 above;
3.7. The revised POC shall comply with 3.3.1 above and be reviewed in accordance with 3.3.2 above;
3.8. If the revised POC is not acceptable to the department, or is not submitted within 21 days of the date of the written notification in 3.5 above, the contractor shall be subject to a directed POC in accordance with 3.12 below;
3.9. The department shall verify the implementation of any POC that has been submitted and accepted by:
  3.9.1. Reviewing materials submitted by the contractor;
  3.9.2. Conducting a follow-up inspection; or
  3.9.3. Reviewing compliance during the next scheduled inspection;
3.10. Verification of the implementation of any POC shall only occur after the date of completion specified by the contractor in the plan; and
3.11. If the POC or revised POC has not been implemented by the completion date, the contractor shall be issued a directed POC in accordance with 3.12 below.
3.12. The department shall develop and impose a directed POC that specifies corrective actions for the contractor to implement when:
  3.12.1. As a result of an inspection, deficiencies were identified that require immediate corrective action to protect the health and safety of the clients or personnel;
  3.12.2. A revised POC is not submitted within 21 days of the written notification from the department; or
  3.12.3. A revised POC submitted has not been accepted.

4. Duties and Responsibilities of All Contractors.
   4.1. The contractor shall comply with all federal, state, and local laws, rules, codes, ordinances, licenses, permits, and approvals, and rules promulgated thereunder, as applicable.
   4.2. The contractor shall monitor, assess, and improve, as necessary, the quality of care and service provided to clients on an ongoing basis.
   4.3. The contractor shall provide for the necessary qualified personnel, facilities, equipment, and supplies for the safety, maintenance and operation of the contractor.
   4.4. The contractor shall develop and implement written policies and procedures governing its operation and all services provided.
   4.5. All policies and procedures shall be reviewed, revised, and trained on per contractor policy.
   4.6. The contractor shall:
      4.6.1. Employ an administrator responsible for the day-to-day operation of the contractor;
      4.6.2. Maintain a current job description and minimum qualifications for the administrator, including the administrator's authority and duties; and
      4.6.3. Establish, in writing, a chain of command that sets forth the line of authority for the operation of the contractor the staff position(s) to be delegated the authority and responsibility to act in the administrator's behalf when the administrator is absent.
   4.7. The contractor shall post the following documents in a public area:
      4.7.1. A copy of the contractor's policies and procedures relative to the implementation of client rights and responsibilities, including client confidentiality per 42 CFR Part 2; and
      4.7.2. The contractor's plan for fire safety, evacuation and emergencies identifying the location of, and access to all fire exits.
   4.8. The contractor or any employee shall not falsify any documentation or provide false or misleading information to the department.
   4.9. The contractor shall comply with all conditions of warnings and administrative remedies issued by the department, and all court orders.
   4.10. The contractor shall admit and allow any department representative to inspect the certified premises and all programs and services that are being provided at any time for the purpose of determining compliance with the contract.
   4.11. The contractor shall:
      4.11.1. Report all critical incidents and sentinel events to the department in accordance with Exhibit A, Section 20.2.3;
      4.11.2. Submit additional information if required by the department; and
      4.11.3. Report the event to other agencies as required by law.
   4.12. The contractor shall implement policies and procedures for reporting:
      4.12.1. Suspected child abuse, neglect or exploitation, in accordance with RSA 169-C:29-30; and
      4.12.2. Suspected abuse, neglect or exploitation of adults, in accordance with RSA 149-F:49.
   4.13. The contractor shall report all positive tuberculosis test results for personnel to the office of disease control in accordance with RSA 141-C:7, He-P 301.02 and He-P 301.03.
   4.14. For residential programs, if the contractor accepts a client who is known to have a disease reportable under He-P 301 or an infectious disease, which is any disease

caused by the growth of microorganisms in the body which might or might not be contagious, the contractor shall follow the required procedures for the care of the clients, as specified by the United States Centers for Disease Control and Prevention 2007 Guideline for Isolation Precautions, Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007.

4.15. Contractors shall implement state and federal regulations on client confidentiality, including provisions outlined in 42 CFR 2.13, RSA 172:8-a, and RSA 318-B:12;

4.16. A contractor shall, upon request, provide a client or the client's guardian or agent, if any, with a copy of his or her client record within the confines for 42 CFR Part 2.

4.17. The contractor shall develop policies and procedures regarding the release of information contained in client records, in accordance with 42 CFR Part 2, the Health Insurance Portability and Accountability Act (HIPAA), and RSA 318-B:10.

4.18. All records required by the contract shall be legible, current, accurate and available to the department during an inspection or investigation conducted in accordance with these rules.

4.19. Any contractor that maintains electronic records shall develop written policies and procedures designed to protect the privacy of clients and personnel that, at a minimum, include:

4.19.1. Procedures for backing up files to prevent loss of data;

4.19.2. Safeguards for maintaining the confidentiality of information pertaining to clients and staff; and

4.19.3. Systems to prevent tampering with information pertaining to clients and staff.

4.20. The contractor's service site(s) shall:

4.20.1. Be accessible to a person with a disability using ADA accessibility and barrier free guidelines per 42 U.S.C. 12131 et seq;

4.20.2. Have a reception area separate from living and treatment areas;

4.20.3. Have private space for personal consultation, charting, treatment and social activities, as applicable;

4.20.4. Have secure storage of active and closed confidential client records; and

4.20.5. Have separate and secure storage of toxic substances.

4.21. The contractor shall establish and monitor a code of ethics for the contractor and its staff, as well as a mechanism for reporting unethical conduct.

The contractor shall maintain specific policies on the following and shall submit these policies to the department for approval no later than 30 days after the effective date of the contract:

4.21.1. Client rights, grievance and appeals policies and procedures;

4.21.2. Progressive discipline, leading to administrative discharge;

4.21.3. Reporting and appealing staff grievances;

4.21.4. Policies on client alcohol and other drug use while in treatment;

4.21.5. Policies on client and employee smoking that are in compliance with Exhibit A, Section 4.1.5;

4.21.6. Drug-free workplace policy and procedures, including a requirement for the filing of written reports of actions taken in the event of staff misuse of alcohol or other drugs;

4.21.7. Policies and procedures for holding a client's possessions;

4.21.8. Secure storage of staff medications;

4.21.9. A client medication policy;

4.21.10. Urine specimen collection, as applicable, that:

4.21.10.1. Ensure that collection is conducted in a manner that preserves client privacy as much as possible; and
4.21.10.2. Minimize falsification;
4.21.11. Safety and emergency procedures on the following:
4.21.11.1. Medical emergencies;
4.21.11.2. Infection control and universal precautions, including the use of protective clothing and devices;
4.21.11.3. Reporting employee injuries;
4.21.11.4. Fire monitoring, warning, evacuation, and safety drill policy and procedures;
4.21.11.5. Emergency closings;
4.21.11.6. Posting of the above safety and emergency procedures.
4.21.12. Procedures for protection of client records that govern use of records, storage, removal, conditions for release of information, and compliance with 42CFR, Part 2 and the Health Insurance Portability and Accountability Act (HIPAA); and
4.21.13. Procedures related to quality assurance and quality improvement.

5. Collection of Fees.
5.1. The contractor shall maintain procedures regarding collections from client fees, private or public insurance, and other payers responsible for the client's finances; and
5.2. At the time of screening and admission the contractor shall provide the client, and the client's guardian, agent, or personal representative, with a listing of all known applicable charges and identify what care and services are included in the charge.
6. Client Screening and Denial of Services.
6.1. Contractors shall maintain a record of all client screenings, including:
6.1.1. The client name and/or unique client identifier;
6.1.2. The client referral source;
6.1.3. The date of initial contact from the client or referring agency;
6.1.4. The date of screening;
6.1.5. The result of the screening, including the reason for denial of services if applicable;
6.1.6. For any client who is placed on a waitlist, record of referrals to and coordination with interim services or reason that such a referral was not made;
6.1.7. Record of all client contacts between screening and removal from the waitlist; and
6.1.8. Date client was removed from the waitlist and the reason for removal
6.2. For any client who is denied services, the contractor is responsible for:
6.2.1. Informing the client of the reason for denial;
6.2.2. Assisting the client in identifying and accessing appropriate available treatment;
6.3. The contractor shall not deny services to a client solely because the client:
6.3.1. Previously left treatment against the advice of staff;
6.3.2. Relapsed from an earlier treatment;
6.3.3. Is on any class of medications, including but not limited to opiates or benzodiazepines; or
6.3.4. Has been diagnosed with a mental health disorder.
6.4. The contractor shall report on 6.1 and 6.2 above at the request of the department.
7. Personnel Requirements.
7.1. The contractor shall develop a current job description for all staff, including contracted staff, volunteers, and student interns, which shall include:
7.1.1. Job title;

7.1.2. Physical requirements of the position;
7.1.3. Education and experience requirements of the position;
7.1.4. Duties of the position;
7.1.5. Positions supervised; and
7.1.6. Title of immediate supervisor.

7.2. The contractor shall develop and implement policies regarding criminal background checks of prospective employees, which shall, at a minimum, include:
7.2.1. Requiring a prospective employee to sign a release to allow the contractor to obtain his or her criminal record;
7.2.2. Requiring the administrator or his or her designee to obtain and review a criminal records check from the New Hampshire department of safety for each prospective employee;
7.2.3. Criminal background standards regarding the following, beyond which shall be reason to not hire a prospective employee in order to ensure the health, safety, or well-being of clients:
7.2.3.1. Felony convictions in this or any other state;
7.2.3.2. Convictions for sexual assault, other violent crime, assault, fraud, abuse, neglect or exploitation; and
7.2.3.3. Findings by the department or any administrative agency in this or any other state for assault, fraud, abuse, neglect or exploitation or any person; and
7.2.4. Waiver of 7.2.3 above for good cause shown.

7.3. All staff, including contracted staff, shall:
7.3.1. Meet the educational, experiential, and physical qualifications of the position as listed in their job description;
7.3.2. Not exceed the criminal background standards established by 7.2.3 above, unless waived for good cause shown, in accordance with policy established in 7.2.4 above;
7.3.3. Be licensed, registered or certified as required by state statute and as applicable;
7.3.4. Receive an orientation within the first 3 days of work or prior to direct contact with clients, which includes:
7.3.4.1. The contractor's code of ethics, including ethical conduct and the reporting of unprofessional conduct;
7.3.4.2. The contractor's policies on client rights and responsibilities and complaint procedures;
7.3.4.3. Confidentiality requirements as required by Sections 4.15 and 4.19.2 above and Section 17 below;
7.3.4.4. Grievance procedures for both clients and staff as required in Section 4.22.1 and 4.22.3 above and Section 18 below.
7.3.4.5. The duties and responsibilities and the policies, procedures, and guidelines of the position they were hired for;
7.3.4.6. Topics covered by both the administrative and personnel manuals;
7.3.4.7. The contractor's infection prevention program;
7.3.4.8. The contractor's fire, evacuation, and other emergency plans which outline the responsibilities of personnel in an emergency; and
7.3.4.9. Mandatory reporting requirements for abuse or neglect such as those found in RSA 161-F and RSA 169-C:29; and
7.3.5. Sign and date documentation that they have taken part in an orientation as described in 7.3.4 above;

7.3.6. Complete a mandatory annual in-service education, which includes a review of all elements described in 7.3.4 above.

7.4. Prior to having contact with clients, employees and contracted employees shall:

7.4.1. Submit to the contractor proof of a physical examination or a health screening conducted not more than 12 months prior to employment which shall include at a minimum the following:

7.4.1.1. The name of the examinee;

7.4.1.2. The date of the examination;

7.4.1.3. Whether or not the examinee has a contagious illness or any other illness that would affect the examinee's ability to perform their job duties;

7.4.1.4. Results of a 2-step tuberculosis (TB) test, Mantoux method or other method approved by the Centers for Disease Control (CDC); and

7.4.1.5. The dated signature of the licensed health practitioner;

7.4.2. Be allowed to work while waiting for the results of the second step of the TB test when the results of the first step are negative for TB; and

7.4.3. Comply with the requirements of the Centers for Disease Control Guidelines for Preventing the Transmission of Tuberculosis in Health Facilities Settings, 2005, if the person has either a positive TB test, or has had direct contact or potential for occupational exposure to Mycobacterium tuberculosis through shared air space with persons with infectious tuberculosis.

7.5. Employees, contracted employees, volunteers and independent contractors who have direct contact with clients who have a history of TB or a positive skin test shall have a symptomatology screen of a TB test.

7.6. The contractor shall maintain and store in a secure and confidential manner, a current personnel file for each employee, student, volunteer, and contracted staff. A personnel file shall include, at a minimum, the following:

7.6.1. A completed application for employment or a resume, including:

7.6.2. Identification data; and

7.6.3. The education and work experience of the employee;

7.6.4. A copy of the current job description or agreement, signed by the individual, that identifies the:

7.6.4.1. Position title;

7.6.4.2. Qualifications and experience; and

7.6.4.3. Duties required by the position;

7.6.5. Written verification that the person meets the contractor's qualifications for the assigned job description, such as school transcripts, certifications and licenses as applicable;

7.6.6. A signed and dated record of orientation as required by 7.3.4 above;

7.6.7. A copy of each current New Hampshire license, registration or certification in health care field and CPR certification, if applicable;

7.6.8. Records of screening for communicable diseases results required in 7.4 above;

7.6.9. Written performance appraisals for each year of employment including description of any corrective actions, supervision, or training determined by the person's supervisor to be necessary;

7.6.10. Documentation of annual in-service education as required by 7.3.6 above;

7.6.11. Information as to the general content and length of all continuing education or educational programs attended;

7.6.12. A signed statement acknowledging the receipt of the contractor's policy setting forth the client's rights and responsibilities, including confidentiality requirements, and acknowledging training and implementation of the policy.

7.6.13. A statement, which shall be signed at the time the initial offer of employment is made and then annually thereafter, stating that he or she:

7.6.13.1. Does not have a felony conviction in this or any other state;

7.6.13.2. Has not been convicted of a sexual assault, other violent crime, assault, fraud, abuse, neglect or exploitation or pose a threat to the health, safety or well-being of a client; and

7.6.13.3. Has not had a finding by the department or any administrative agency in this or any other state for assault, fraud, abuse, neglect or exploitation of any person; and

7.6.14. Documentation of the criminal records check and any waivers per 7.2 above.

7.7. An individual need not re-disclose any of the matters in 7.6.13 and 7.6.14 above if the documentation is available and the contractor has previously reviewed the material and granted a waiver so that the individual can continue employment.

8. Clinical Supervision.

8.1. Contractors shall comply with the following clinical supervision requirements for unlicensed counselors:

8.1.1. Each unlicensed alcohol and drug counselor or Certified Recovery Support Worker (CRSW) shall be supervised by a New Hampshire–MLADC or LADC with the LCS credential at a ratio of one LADC to every 2 full-time equivalent positions that are unlicensed alcohol and drug counselors or CRSWs;

8.1.2. Unlicensed counselors shall receive at least one hour of supervision for every 20 hours of direct client contact;

8.1.3. Supervision shall be provided on an individual or group basis, or both, depending upon the employee's need, experience and skill level;

8.1.4. Supervision shall include following techniques:

8.1.4.1. Review of case records;

8.1.4.2. Observation of interactions with clients;

8.1.4.3. Skill development; and

8.1.4.4. Review of case management activities; and

8.1.5. Supervisors shall maintain a log of the supervision date, duration, content and who was supervised by whom;

8.1.6. Individuals licensed or certified by the NH Board of Licensing for Alcohol and Other Drug Use Professionals shall receive supervision in accordance with RSA 330-C and the rules promulgated thereunder.

9. Clinical Services.

9.1. Each contractor shall have and adhere to a clinical care manual which includes policies and procedures related to all clinical services provided.

9.2. All clinical services provided shall:

9.2.1. Focus on the client's strengths;

9.2.2. Be sensitive and relevant to the diversity of the clients being served;

9.2.3. Be client and family centered;

9.2.4. Be trauma informed, which means designed to acknowledge the impact of violence and trauma on people's lives and the importance of addressing trauma in treatment; and

9.3. Upon a client's admission, the contractor shall conduct a client orientation, either individually or by group, to include the following:

9.3.1. Rules, policies, and procedures of the contractor, program, and facility;
9.3.2. Requirements for successfully completing the program;
9.3.3. The administrative discharge policy and the grounds for administrative discharge;
9.3.4. All applicable laws regarding confidentiality, including the limits of confidentiality and mandatory reporting requirements; and
9.3.5. Requiring the client to sign a receipt that the orientation was conducted.
9.3.6. Upon a client's admission to treatment, the contractor shall conduct an HIV/AIDS screening, to include:
9.3.7. The provision of information;
9.3.8. Risk assessment;
9.3.9. Intervention and risk reduction education, and
9.3.10. Referral for testing, if appropriate, within 7 days of admission;

10. Treatment and Rehabilitation.
10.1. A LADC or unlicensed counselor under the supervision of a LADC shall develop and maintain a written treatment plan for each client in accordance with TAP 21: Addiction Counseling Competencies available at http://store.samhsa.gov/list/series?name=Technical-Assistance-Publications-TAPs-&pageNumber=1 which addresses all ASAM domains.
10.2. Treatment plans shall be developed as follows:
10.2.1. Within 7 days following admission to any residential program; and
10.2.2. No later than the third session of an ambulatory treatment program.
10.3. Individual treatment plans shall contain, at a minimum, the following elements:
10.3.1. Goals, objectives, and interventions written in terms that are specific, measurable, attainable, realistic and timely.
10.3.2. Identifies the recipient's clinical needs, treatment goals, and objectives;
10.3.3. Identifies the client's strengths and resources for achieving goals and objectives in 10.3.1 above;
10.3.4. Defines the strategy for providing services to meet those needs, goals, and objectives;
10.3.5. Identifies referral to outside contractors for the purpose of achieving a specific goal or objective when the service cannot be delivered by the treatment program;
10.3.6. Provides the criteria for terminating specific interventions; and
10.3.7. Includes specification and description of the indicators to be used to assess the individual's progress.
10.3.8. Documentation of participation by the client in the treatment planning process or the reason why the client did not participate; and
10.3.9. Signatures of the client and the counselor agreeing to the treatment plan, or if applicable, documentation of the client's refusal to sign the treatment plan.
10.4. Treatment plans shall be updated based on any changes in any American Society of Addiction Medicine Criteria (ASAM) domain and no less frequently than every 4 sessions or every 4 weeks, whichever is less frequent.
10.5. Treatment plan updates shall include:
10.5.1. Documentation of the degree to which the client is meeting treatment plan goals and objectives;
10.5.2. Modification of existing goals or addition of new goals based on changes in the clients functioning relative to ASAM domains and treatment goals and objectives.

10.5.3. The counselor's assessment of whether or not the client needs to move to a different level of care based on changes in functioning in any ASAM domain and documentation of the reasons for this assessment.

10.5.4. The signature of the client and the counselor agreeing to the updated treatment plan, or if applicable, documentation of the client's refusal to sign the treatment plan.

10.6. In addition to the individualized treatment planning in 10.3 above, all contractors shall provide client education on:

10.6.1. Substance use disorders;

10.6.2. Relapse prevention;

10.6.3. Infectious diseases associated with injection drug use, including but not limited to, HIV, hepatitis, and TB;

10.6.4. Sexually transmitted diseases;

10.6.5. Emotional, physical, and sexual abuse;

10.6.6. Nicotine use disorder and cessation options;

10.6.7. The impact of drug and alcohol use during pregnancy, risks to the fetus, and the importance of informing medical practitioners of drug and alcohol use during pregnancy

10.7. Group education and counseling

10.7.1. The contractor shall maintain an outline of each educational and group therapy session provided.

10.7.2. All group counseling sessions shall be limited to 12 clients or fewer per counselor.

10.8. Progress notes

10.8.1. A progress note shall be completed for each individual, group, or family treatment or education session.

10.8.2. Each progress note shall contain the following components:

10.8.2.1. Data, including self-report, observations, interventions, current issues/stressors, functional impairment, interpersonal behavior, motivation, and progress, as it relates to the current treatment plan;

10.8.2.2. Assessment, including progress, evaluation of intervention, and obstacles or barriers; and

10.8.2.3. Plan, including tasks to be completed between sessions, objectives for next session, any recommended changes, and date of next session; and

10.9. Residential programs shall maintain a daily shift change log which documents such things as client behavior and significant events that a subsequent shift should be made aware of.

11. Client Discharge and Transfer.

11.1. A client shall be discharged from a program for the following reasons:

11.1.1. Program completion or transfer based on changes in the client's functioning relative to ASAM criteria;

11.1.2. Program termination, including:

11.1.2.1. Administrative discharge;

11.1.2.2. Non-compliance with the program;

11.1.2.3. The client left the program before completion against advice of treatment staff; and

11.1.3. The client is inaccessible, such as the client has been jailed or hospitalized; and

11.2. In all cases of client discharge or transfer, the counselor shall complete a narrative discharge summary, including, at a minimum:

11.2.1. The dates of admission and discharge or transfer;
11.2.2. The client's psychosocial substance abuse history and legal history;
11.2.3. A summary of the client's progress toward treatment goals in all ASAM domains;
11.2.4. The reason for discharge or transfer;
11.2.5. The client's DSM 5 diagnosis and summary, to include other assessment testing completed during treatment;
11.2.6. A summary of the client's physical condition at the time of discharge or transfer;
11.2.7. A continuing care plan, including all ASAM domains;
11.2.8. A determination as to whether the client would be eligible for re-admission to treatment, if applicable; and
11.2.9. The dated signature of the counselor completing the summary.

11.3. The discharge summary shall be completed:
11.3.1. No later than 7 days following a client's discharge or transfer from the program; or
11.3.2. For withdrawal management services, by the end of the next business day following a client's discharge or transfer from the program.

11.4. When transferring a client, either from one level of care to another within the same certified contractor agency or to another treatment contractor, the counselor shall:
11.4.1. Complete a progress note on the client's treatment and progress towards treatment goals, to be included in the client's record; and
11.4.2. Update the client assessment and treatment plan.

11.5. When transferring a client to another treatment contractor, the current contractor shall forward copies of the following information to the receiving contractor, only after a release of confidential information is signed by the client:
11.5.1. The discharge summary;
11.5.2. Client demographic information, including the client's name, date of birth, address, telephone number, and the last 4 digits of his or her Social Security number; and
11.5.3. A diagnostic assessment statement and other assessment information, including:
11.5.3.1. TB test results;
11.5.3.2. A record of the client's treatment history; and
11.5.3.3. Documentation of any court-mandated or agency-recommended follow-up treatment.

11.6. The counselor shall meet with the client at the time of discharge or transfer to establish a continuing care plan that:
11.6.1. Includes recommendations for continuing care in all ASAM domains;
11.6.2. Addresses the use of self-help groups including, when indicated, facilitated self-help; and
11.6.3. Assists the client in making contact with other agencies or services.

11.7. The counselor shall document in the client record if and why the meeting in Section 11.6 above could not take place.

11.8. A contractor may administratively discharge a client from a program only if:
11.8.1. The client's behavior on program premises is abusive, violent, or illegal;
11.8.2. The client is non-compliant with prescription medications;
11.8.3. Clinical staff documents therapeutic reasons for discharge, which may include the client's continued use of illicit drugs or an unwillingness to follow appropriate clinical interventions; or

11.8.4. The client violates program rules in a manner that is consistent with the contractor's progressive discipline policy.

12. Client Record System.

12.1. Each contractor shall have policies and procedures to implement a comprehensive client record system, in either paper form or electronic form, or both, that complies with this section.

The client record of each client served shall communicate information in a manner that is:

12.1.1. Organized into related sections with entries in chronological order;

12.1.2. Easy to read and understand;

12.1.3. Complete, containing all the parts; and

12.1.4. Up-to-date, including notes of most recent contacts.

12.2. The client record shall include, at a minimum, the following components, organized as follows:

12.2.1. First section, Intake/Initial Information:

12.2.1.1. Identification data, including the client's:

12.2.1.1.1. Name;

12.2.1.1.2. Date of birth;

12.2.1.1.3. Address;

12.2.1.1.4. Telephone number; and

12.2.1.1.5. The last 4 digits of the client's Social Security number;

12.2.1.2. The date of admission;

12.2.1.3. If either of these have been appointed for the client, the name and address of:

12.2.1.3.1. The guardian; and

12.2.1.3.2. The representative payee;

12.2.1.4. The name, address, and telephone number of the person to contact in the event of an emergency;

12.2.1.5. Contact information for the person or entity referring the client for services, as applicable;

12.2.1.6. The name, address, and telephone number of the primary health care contractor;

12.2.1.7. The name, address, and telephone number of the behavioral health care contractor, if applicable;

12.2.1.8. The name and address of the client's public or private health insurance contractor(s), or both;

12.2.1.9. The client's religious preference, if any;

12.2.1.10. The client's personal health history;

12.2.1.11. The client's mental health history;

12.2.1.12. Current medications;

12.2.1.13. Records and reports prepared prior to the client's current admission and determined by the counselor to be relevant; and

12.2.1.14. Signed receipt of notification of client rights;

12.2.2. Second section, Screening/Assessment/Evaluation:

12.2.2.1. Documentation of all elements of screening, assessment and evaluation required by Exhibit A, Sections 6 and 10.2;

12.2.3. Third section, Treatment Planning:

12.2.3.1. The individual treatment plan, updated at designated intervals in accordance with Sections 10.2 – 10.5 above; and

12.2.3.2. Signed and dated progress notes and reports from all programs involved, as required by Section 10.8 above;

12.2.4. Fourth section, Discharge Planning:

12.2.4.1. A narrative discharge summary, as required by Sections 11.2 and 11.3 above;

12.2.5. Fifth section, Releases of Information/Miscellaneous:

12.2.5.1. Release of information forms compliant with 42 CFR, Part 2;

12.2.5.2. Any correspondence pertinent to the client; and

12.2.5.3. Any other information the contractor deems significant.

12.3. If the contractor utilizes a paper format client record system, then the sections in Section 12.3 above shall be tabbed sections.

12.4. If the contractor utilizes an electronic format, the sections in Section 12.3 above shall not apply provided that all information listed in Section 12.3 above is included in the electronic record.

12.5. All client records maintained by the contractor or its sub-contractors, including paper files, facsimile transmissions, or electronic data transfers, shall be strictly confidential.

12.6. All confidential information shall be maintained within a secure storage system at all times as follows:

12.6.1. Paper records and external electronic storage media shall be kept in locked file cabinets;

12.6.2. All electronic files shall be password protected; and

12.6.3. All confidential notes or other materials that do not require storage shall be shredded immediately after use.

12.6.4. Contractors shall retain client records after the discharge or transfer of the client, as follows:

12.6.4.1. For a minimum of 7 years for an adult; and

12.6.4.2. For a minimum of 7 years after age of majority for children.

12.7. In the event of a program closure, the contractor closing its treatment program shall arrange for the continued management of all client records. The closing contractor shall notify the department in writing of the address where records will be stored and specify the person managing the records.

12.8. The closing contractor shall arrange for storage of each record through one or more of the following measures:

12.8.1. Continue to manage the records and give written assurance to the department that it will respond to authorized requests for copies of client records within 10 working days;

12.8.2. Transfer records of clients who have given written consent to another contractor; or

12.8.3. Enter into a limited service organization agreement with another contractor to store and manage records.

13. Medication Services.

13.1. No administration of medications, including physician samples, shall occur except by a licensed medical practitioner working within their scope of practice.

13.2. All prescription medications brought by a client to program shall be in their original containers and legibly display the following information:

13.2.1. The client's name;

13.2.2. The medication name and strength;

13.2.3. The prescribed dose;

13.2.4. The route of administration;

13.2.5. The frequency of administration; and
13.2.6. The date ordered.
13.3. Any change or discontinuation of prescription medications shall require a written order from a licensed practitioner.
13.4. All prescription medications, with the exception of nitroglycerin, epi-pens, and rescue inhalers, which may be kept on the client's person or stored in the client's room, shall be stored as follows:
13.4.1. All medications shall be kept in a storage area that is:
13.4.1.1. Locked and accessible only to authorized personnel;
13.4.1.2. Organized to allow correct identification of each client's medication(s);
13.4.1.3. Illuminated in a manner sufficient to allow reading of all medication labels; and
13.4.1.4. Equipped to maintain medication at the proper temperature;
13.4.2. Schedule II controlled substances, as defined by RSA 318-B:1-b, shall be kept in a separately locked compartment within the locked medication storage area and accessible only to authorized personnel; and
13.4.3. Topical liquids, ointments, patches, creams and powder forms of products shall be stored in a manner such that cross-contamination with oral, optic, ophthalmic, and parenteral products shall not occur.
13.5. Medication belonging to personnel shall not be accessible to clients, nor stored with client medication.
13.6. Over-the-counter (OTC) medications shall be handled in the following manner:
13.6.1. Only original, unopened containers of OTC medications shall be allowed to be brought into the program;
13.6.2. OTC medication shall be stored in accordance with Section 13.4 above.
13.6.3. OTC medication containers shall be marked with the name of the client using the medication and taken in accordance with the directions on the medication container or as ordered by a licensed practitioner;
13.7. All medications self-administered by a client, with the exception of nitroglycerin, epi-pens, and rescue inhalers, which may be taken by the client without supervision, shall be supervised by the program staff, as follows:
13.7.1. Staff shall remind the client to take the correct dose of his or her medication at the correct time;
13.7.2. Staff may open the medication container but shall not be permitted to physically handle the medication itself in any manner;
13.7.3. Staff shall remain with the client to observe them taking the prescribed dose and type of medication;
13.8. For each medication taken, staff shall document in an individual client medication log the following:
13.8.1. The medication name, strength, dose, frequency and route of administration;
13.8.2. The date and the time the medication was taken;
13.8.3. The signature or identifiable initials of the person supervising the taking of said medication; and
13.8.4. The reason for any medication refused or omitted.
13.9. Upon a client's discharge:
13.9.1. The client medication log in Section 13.8 above shall be included in the client's record; and
13.9.2. The client shall be given any remaining medication to take with him or her
14. Notice of Client Rights

14.1. Programs shall inform clients of their rights under these rules in clear, understandable language and form, both verbally and in writing as follows:
14.1.1. Applicants for services shall be informed of their rights to evaluations and access to treatment;
14.1.2. Clients shall be advised of their rights upon entry into any program and at least once a year after entry;
14.1.3. Initial and annual notifications of client rights in Section 14 above shall be documented in the client's record; and
14.2. Every program within the service delivery system shall post notice of the rights, as follows:
14.2.1. The notice shall be posted continuously and conspicuously;
14.2.2. The notice shall be presented in clear, understandable language and form; and
14.2.3. Each program and residence shall have on the premises complete copies of rules pertaining to client rights that are available for client review.

15. Fundamental Rights.
15.1. No person receiving treatment for a substance use disorder shall be deprived of any legal right to which all citizens are entitled solely by reason of that person's admission to the treatment services system.

16. Personal Rights.
16.1. Persons who are applicants for services or clients in the service delivery system shall be treated by program staff with dignity and respect at all times.
16.2. Clients shall be free from abuse, neglect and exploitation including, at a minimum, the following:
16.2.1. Freedom from any verbal, non-verbal, mental, physical, or sexual abuse or neglect;
16.2.2. Freedom from the intentional use of physical force except the minimum force necessary to prevent harm to the client or others; and
16.2.3. Freedom from personal or financial exploitation.
16.3. Clients shall have the right to privacy.

17. Client Confidentiality
17.1. All contractors shall adhere to the confidentiality requirements in 42 CFR part 2.
17.2. In cases where a client, attorney or other authorized person, after review of the record, requests copies of the record, a program shall make such copies available free of charge for the first 25 pages and not more than 25 cents per page thereafter.
17.3. If a minor age 12 or older is treated for drug abuse without parental consent as authorized by RSA 318:B12-a, the following shall apply:
17.3.1. The minor's signature alone shall authorize a disclosure; and
17.3.2. Any disclosure to the minor's parents or guardians shall require a signed authorization to release.

18. Client Grievances
18.1. Clients shall have the right to complain about any matter, including any alleged violation of a right afforded by these rules or by any state or federal law or rule.
18.2. Any person shall have the right to complain or bring a grievance on behalf of an individual client or a group of clients.
18.3. The rules governing procedures for protection of client rights found at He-C 200 shall apply to such complaints and grievances.

19. Treatment Rights.
19.1. Each client shall have the right to adequate and humane treatment, including:
19.1.1. The right of access to treatment including:

19.1.1.1. The right to evaluation to determine an applicant's need for services and to determine which programs are most suited to provide the services needed;
19.1.1.2. The right to provision of necessary services when those services are available, subject to the admission and eligibility policies and standards of each program; and
19.1.2. The right to quality treatment including:
19.1.2.1. Services provided in keeping with evidence-based clinical and professional standards applicable to the persons and programs providing the treatment and to the conditions for which the client is being treated;
19.1.3. The right to receive services in such a manner as to promote the client's full participation in the community;
19.1.4. The right to receive all services or treatment to which a person is entitled in accordance with the time frame set forth in the client's individual treatment plan;
19.1.5. The right to an individual treatment plan developed, reviewed and revised in accordance with Sections 10.1 – 10.5 above which addresses the client's own goals;
19.1.6. The right to receive treatment and services contained in an individual treatment plan designed to provide opportunities for the client to participate in meaningful activities in the communities in which the client lives and works;
19.1.7. The right to service and treatment in the least restrictive alternative or environment necessary to achieve the purposes of treatment including programs which least restrict:
19.1.7.1. Freedom of movement; and
19.1.7.2. Participation in the community, while providing the level of support needed by the client;
19.1.8. The right to be informed of all significant risks, benefits, side effects and alternative treatment and services and to give consent to any treatment, placement or referral following an informed decision such that:
19.1.8.1. Whenever possible, the consent shall be given in writing; and
19.1.8.2. In all other cases, evidence of consent shall be documented by the program and shall be witnessed by at least one person;
19.1.9. The right to refuse to participate in any form of experimental treatment or research;
19.1.10. The right to be fully informed of one's own diagnosis and prognosis;
19.1.11. The right to voluntary placement including the right to:
19.1.11.1. Seek changes in placement, services or treatment at any time; and
19.1.11.2. Withdraw from any form of voluntary treatment or from the service delivery system;
19.1.12. The right to services which promote independence including services directed toward:
19.1.12.1. Eliminating, or reducing as much as possible, the client's needs for continued services and treatment; and
19.1.12.2. Promoting the ability of the clients to function at their highest capacity and as independently as possible;
19.1.13. The right to refuse medication and treatment;
19.1.14. The right to referral for medical care and treatment including, if needed, assistance in finding such care in a timely manner;
19.1.15. The right to consultation and second opinion including:
19.1.15.1. At the client's own expense, the consultative services of:

19.1.15.1.1. Private physicians;
19.1.15.1.2. Psychologists;
19.1.15.1.3. Licensed drug and alcohol counselors; and
19.1.15.1.4. Other health practitioners; and

19.1.15.2. Granting to such health practitioners reasonable access to the client, as required by Section 19.1.15, in programs and allowing such practitioners to make recommendations to programs regarding the services and treatment provided by the programs;

19.1.16. The right, upon request, to have one or more of the following present at any treatment meeting requiring client participation and informed decision-making:
19.1.16.1. Guardian;
19.1.16.2. Representative;
19.1.16.3. Attorney;
19.1.16.4. Family member;
19.1.16.5. Advocate; or
19.1.16.6. Consultant; and

19.1.17. The right to freedom from restraint including the right to be free from seclusion and physical, mechanical or pharmacological restraint.

19.2. No treatment professional shall be required to administer treatment contrary to such professional's clinical judgment.

19.3. Programs shall, whenever possible, maximize the decision-making authority of the client.

19.4. In furtherance of Section 19.3 above, the following provisions shall apply to clients for whom a guardian has been appointed by a court of competent jurisdiction:

19.4.1. The program shall ensure that in the course of service provision, the guardian and all persons involved in the provision of service are made aware of the client's views, preferences and aspirations;

19.4.2. A guardian shall only make decisions that are within the scope of the powers set forth in the guardianship order issued by the court;

19.4.3. The program shall request a copy of the guardianship order from the guardian and the order shall be kept in the client's record at the program;

19.4.4. If any issues arise relative to the provision of services and supports which are outside the scope of the guardian's decision-making authority as set forth in the guardianship order, the client's choice and preference relative to those issues shall prevail unless the guardian's authority is expanded by the court to include those issues;

19.4.5. A program shall take such steps as are necessary to prevent a guardian from exceeding the decision-making authority granted by the court including:
19.4.5.1. Reviewing with the guardian the limits on his or her decision-making authority; and
19.4.5.2. If necessary, bringing the matter to the attention of the court that appointed the guardian;

19.4.6. The guardian shall act in a manner that furthers the best interests of the client;

19.4.7. In acting in the best interests of the client, the guardian shall take into consideration the views, preferences and aspirations of the client;

19.4.8. The program shall take such steps as are necessary to prevent a guardian from acting in a manner that does not further the best interests of the client and, if necessary, bring the matter to the attention of the court that appointed the guardian; and

19.4.9. In the event that there is a dispute between the program and the guardian, the program shall inform the guardian of his or her right to bring the dispute to the attention of the probate court that appointed the guardian.

20. Termination of Services.
    20.1. A client shall be terminated from a contractor's service if the client:
        20.1.1. Endangers or threatens to endanger other clients or staff, or engages in illegal activity on the property of the program;
        20.1.2. Is no longer benefiting from the service(s) he or she is receiving;
        20.1.3. Cannot agree with the program on a mutually acceptable course of treatment;
        20.1.4. Refuses to pay for the services that he or she is receiving despite having the financial resources to do so; or
        20.1.5. Refuses to apply for benefits that could cover the cost of the services that he or she is receiving despite the fact that the client is or might be eligible for such benefits.
    20.2. A termination from a contractor's services shall not occur unless the program has given both written and verbal notice to the client and client's guardian, if any, that:
        20.2.1. Give the effective date of termination;
        20.2.2. List the clinical or management reasons for termination; and
        20.2.3. Explain the rights to appeal and the appeal process pursuant to He-C 200.
    20.3. A contractor shall document in the record of a client who has been terminated that:
        20.3.1. The client has been notified of the termination; and
        20.3.2. The termination has been approved by the program director.
21. Client Rights in Residential Programs.
    21.1. In addition to the foregoing rights, clients of residential programs shall also have the following rights:
        21.1.1. The right to a safe, sanitary and humane living environment;
        21.1.2. The right to privately communicate with others, including:
            21.1.2.1. The right to send and receive unopened and uncensored correspondence;
            21.1.2.2. The right to have reasonable access to telephones and to be allowed to make and to receive reasonable numbers of telephone calls except that residential programs may require a client to reimburse them for the cost of any calls made by the client;
            21.1.2.3. The right to receive and to refuse to receive visitors except that residential programs may impose reasonable restrictions on the number and time of visits in order to ensure effective provision of services; and
        21.1.3. The right to engage in social and recreational activities including the provision of regular opportunities for clients to engage in such activities;
        21.1.4. The right to privacy, including the following:
            21.1.4.1. The right to courtesies such as knocking on closed doors before entering and ensuring privacy for telephone calls and visits;
            21.1.4.2. The right to opportunities for personal interaction in a private setting except that any conduct or activity which is illegal shall be prohibited; and
            21.1.4.3. The right to be free from searches of their persons and possessions except in accordance with applicable constitutional and legal standards;
        21.1.5. The right to individual choice, including the following:
            21.1.5.1. The right to keep and wear their own clothes;
            21.1.5.2. The right to space for personal possessions;
            21.1.5.3. The right to keep and to read materials of their own choosing;
            21.1.5.4. The right to keep and spend their own money; and

21.1.5.5. The right not to work and to be compensated for any work performed, except that:

21.1.5.5.1. Clients may be required to perform personal housekeeping tasks within the client's own immediate living area and equitably share housekeeping tasks within the common areas of the residence, without compensation; and

21.1.5.5.2. Clients may perform vocational learning tasks or work required for the operation or maintenance of a residential program, if the work is consistent with their individual treatment plans and the client is compensated for work performed; and

21.1.6. The right to be reimbursed for the loss of any money held in safekeeping by the residence.

21.2. Nothing in Section 21 shall prevent a residence from having policies governing the behavior of the residents.

21.3. Clients shall be informed of any house policies upon admission to the residence.

21.4. House policies shall be posted and such policies shall be in conformity with this section.

21.5. House policies shall be periodically reviewed for compliance with this section in connection with quality assurance site visits.

21.6. Notwithstanding Section 21.1.4.3 above, contractors may develop policies and procedures that allow searches for alcohol and illicit drugs be conducted:

21.6.1. Upon the client's admission to the program; and

21.6.2. If probable cause exists, including such proof as:

21.6.2.1. A positive test showing presence of alcohol or illegal drugs; or

21.6.2.2. Showing physical signs of intoxication or withdrawal.

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that Goodwin Community Health is a New Hampshire nonprofit corporation formed August 18, 1971. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.

In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 12th day of April A.D. 2016

William M. Gardner
Secretary of State

CERTIFICATE OF VOTE

I, David Staples, DDS, of Goodwin Community Health, do hereby certify that:

1. I am the duly elected Board Chair of Goodwin Community Health;

2. The following are true copies of two resolutions duly adopted at a meeting of the Board of Directors of Goodwin Community Health, duly held on January 19, 2016;

   Resolved: That this corporation enter into a contract with the State of New Hampshire, acting through its Department of Health and Human Services for the provision of Public Health Services.

   Resolved: That the Chief Executive Officer, Janet Laatsch, is hereby authorized on behalf of this Corporation to enter into the said contract with the State and to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, as he/she may deem necessary, desirable or appropriate.

3. The foregoing resolutions have not been amended or revoked and remain in full force and effect as of April 12, 2016.

IN WITNESS WHEREOF, I have hereunto set my hand as the Board Chair of the Goodwin Community Health this 12th day of April, 2016.

David Staples, DDS, Board Chair

STATE OF NH

COUNTY OF STRAFFORD

The foregoing instrument was acknowledged before me this 12 day of April, 2016 by David Staples, DDS.

Notary Public/Justice of the Peace

My Commission Expires: 9-17-19

GOODCOM-01 LMICHALS

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 8/11/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER License # AGR8150 Clark Insurance 80 Canal St Manchester, NH 03101	CONTACT NAME: Lorraine Michals PHONE (A/C, No, Ext): (603) 622-2855 FAX (A/C, No): (603) 622-2854 E-MAIL ADDRESS: info@clarkinsurance.com
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A : Acadia — 31325
INSURED Goodwin Community Health 311 Route 108 Somersworth, NH 03878	INSURER B :
	INSURER C :
	INSURER D :
	INSURER E :
	INSURER F :

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY			ADV5212020-10	07/31/2015	07/31/2016	EACH OCCURRENCE	$ 1,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 300,000
							MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 2,000,000
	X POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$ 2,000,000
	OTHER:							$
A	AUTOMOBILE LIABILITY			ADV5212020-10	07/31/2015	07/31/2016	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,0
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	X HIRED AUTOS / X NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
A	X UMBRELLA LIAB X OCCUR			CUA5214125-10	07/31/2015	07/31/2016	EACH OCCURRENCE	$ 1,000,000
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$ 1,000,000
	DED X RETENTION $ 0							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N	N/A		WCA5212021-10	07/31/2015	07/31/2016	X PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH)						E.L. EACH ACCIDENT	$ 500,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 500,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Department of Health and Human Services
Contracts and Procurement Unit
129 Pleasant Street
Concord, NH 03301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

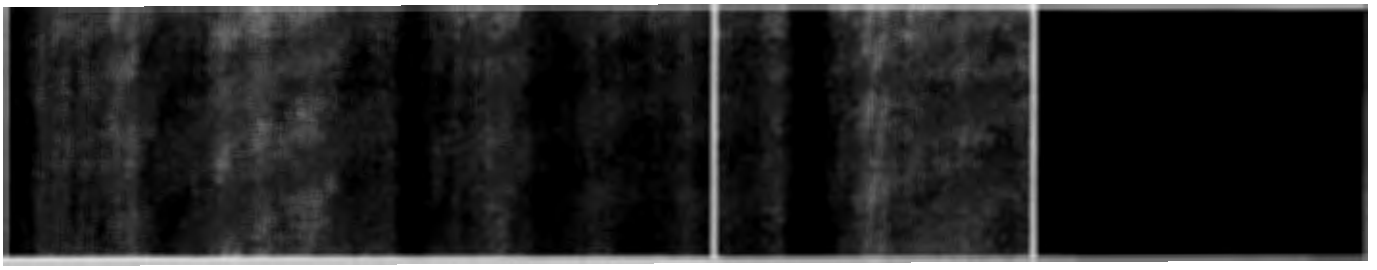
Goodwin
Community Health

Mission

To provide exceptional health care that is accessible to all people in the community.

Board Approved on 6-11-2015

BerryDunn



GOODWIN COMMUNITY HEALTH AND SUBSIDIARY

CONSOLIDATED FINANCIAL STATEMENTS

and

ADDITIONAL INFORMATION

June 30, 2015 and 2014

With Independent Auditor's Report

BerryDunn

INDEPENDENT AUDITOR'S REPORT

Board of Directors
Goodwin Community Health and Subsidiary

We have audited the accompanying consolidated financial statements of Goodwin Community Health and Subsidiary (the Organization), which comprise the consolidated balance sheet as of June 30, 2015, and the related consolidated statements of operations and changes in net assets and cash flows for the year then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We conducted our audit in accordance with U.S. generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Goodwin Community Health and Subsidiary as of June 30, 2015, and the results of their operations, changes in their net assets and their cash flows for the year then ended, in accordance with U.S. generally accepted accounting principles.

Auditor's Updated Opinion on 2015 Consolidated Financial Statements

In our report dated October 15, 2015, we expressed an unmodified opinion that the 2015 consolidated financial statements. The 2015 consolidated financial statements have been revised to correct the amount of cash used by investing activities on the consolidated statement of cash flows. The auditor's opinion is not modified with respect to that matter.

Adjustments to Prior Period Summarized Comparative Information

The consolidated financial statements of the Organization as of June 30, 2014 were audited by another auditor whose opinion dated November 25, 2014, on those statements was unmodified. As disclosed in Note 1, the Organization has restated its 2014 consolidated financial statements during 2015 to change the classification of grants received for capital acquisition previously placed in service and released over the life of the related assets from temporarily restricted net assets to unrestricted net assets, to establish a contractual allowance reserve for the differences between amounts billed to third-party payers and amounts expected to be paid, and to record additional grant funds receivable, in accordance with U.S. generally accepted accounting principles. The other auditor reported on the 2014 consolidated financial statements before the restatement.

As part of our audit of the 2015 consolidated financial statements, we also audited adjustments described in Note 1 that were applied to restate the accompanying 2014 consolidated financial statements. In our opinion, such adjustments are appropriate and have been properly applied. We were not engaged to audit, review or apply any procedures to the 2014 consolidated financial statements of the Organization other than with respect to the adjustments and, accordingly, we do not express an opinion or any form of assurance on the 2014 consolidated financial statements as a whole.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying supplementary information, which consists of the consolidating statement of financial position as of June 30, 2015, and the related consolidating statements of operations and changes in net assets for the year then ended, is presented for purposes of additional analysis rather than to present the financial position and changes in net assets of the individual entities, and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from, and relates directly to, the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with U.S. generally accepted auditing standards. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Berry Dunn McNeil & Parker, LLC

Concord, New Hampshire
December 11, 2015

GOODWIN COMMUNITY HEALTH AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2015 and 2014

ASSETS

	2015	Restated 2014
Current assets		
Cash and cash equivalents	$ 1,669,888	$ 655,579
Patient accounts receivable, less allowance for uncollectible accounts of $81,378 in 2015 and $88,420 in 2014	535,278	369,847
Grants receivable	472,843	162,610
Other current assets	25,472	17,145
Total current assets	2,703,481	1,205,181
Investments	200,125	-
Property and equipment, net	6,147,683	6,276,033
Goodwill	17,582	17,582
Other assets	-	8,010
Total assets	$ 9,068,871	$ 7,506,806

LIABILITIES AND NET ASSETS

Current liabilities		
Line of credit	$ 56,500	$ 193,500
Accounts payable and accrued expenses	183,799	181,237
Accrued payroll and related expenses	433,480	363,823
Current maturities of long-term debt	161,740	154,716
Total current liabilities	835,519	893,276
Long-term debt, less current maturities	708,281	869,885
Total liabilities	1,543,800	1,763,161
Net assets		
Unrestricted	7,525,071	5,743,645
Total liabilities and net assets	$ 9,068,871	$ 7,506,806

The accompanying notes are an integral part of these consolidated financial statements.

GOODWIN COMMUNITY HEALTH AND SUBSIDIARIES

Consolidated Statements of Operations and Changes in Net Assets

Years Ended June 30, 2015 and 2014

	2015	Restated 2014
Operating revenue and support		
Patient service revenue	$ 6,146,046	$ 4,750,323
Provision for bad debts	(255,044)	(304,004)
Net patient service revenue	5,891,002	4,446,319
Grants, contracts, and contributions	3,220,688	2,492,463
Other operating revenue	210,156	164,404
Total operating revenue and support	9,321,846	7,103,186
Operating expenses		
Salaries and benefits	5,914,818	5,302,071
Other operating expenses	1,451,831	1,284,577
Depreciation	253,743	271,833
Interest expense	45,425	57,245
Total operating expenses	7,665,817	6,915,726
Excess of revenues over expenses	1,656,029	187,460
Grants for capital acquisition	125,397	-
Increase in unrestricted net assets	1,781,426	187,460
Unrestricted net assets, beginning of year	5,743,645	5,556,185
Unrestricted net assets, end of year	$ 7,525,071	$ 5,743,645

The accompanying notes are an integral part of these consolidated financial statements.

GOODWIN COMMUNITY HEALTH AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years Ended June 30, 2015 and 2014

	2015	Restated 2014
Cash flows from operating activities		
Change in net assets	$ 1,781,426	$ 187,460
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Provision for bad debts	255,044	304,004
Depreciation	253,743	271,833
Grants for capital acquisition	(125,397)	-
Debt forgiveness	(25,000)	-
(Increase) decrease in		
Patient accounts receivable	(420,475)	(443,911)
Grants receivable	(310,233)	(54,428)
Other assets	(317)	15,012
Increase (decrease) in		
Accounts payable and accrued expenses	2,562	(79,493)
Accrued salaries and related amounts	69,657	43,051
Net cash provided by operating activities	1,481,010	243,528
Cash flows from investing activities		
Capital acquisitions	(125,393)	-
Purchase of investments	(200,125)	-
Net cash used by investing activities	(325,518)	-
Cash flows from financing activities		
Grants for capital acquisition	125,397	-
Payments on long-term debt	(154,580)	(137,656)
Proceeds from long-term debt	-	99,000
Payments on line of credit	(112,000)	(133,780)
Net cash used by financing activities	(141,183)	(172,436)
Net increase in cash and cash equivalents	1,014,309	71,092
Cash and cash equivalents, beginning of year	655,579	584,487
Cash and cash equivalents, end of year	$ 1,669,888	$ 655,579
Supplemental disclosures of cash flow information:		
Cash paid for interest	$ 57,245	$ 57,245
Noncash transaction - debt forgiveness	25,000	-

The accompanying notes are an integral part of these consolidated financial statements.

Organization

Goodwin Community Health (GCH) is a non-stock, not-for-profit corporation organized in New Hampshire. GCH is a Federally Qualified Health Center (FQHC) which provides prenatal care, social support, and public health services to low-income persons.

Subsidiary

Great Bay Mental Health Associates, Inc. (GBMHA), a wholly-owned for-profit subsidiary, engaged in providing mental health services in the Strafford County, New Hampshire community through its employees and independent contractors who are qualified and licensed to practice in the State of New Hampshire.

1. Summary of Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements include the accounts of GCH and its subsidiary, GBMHA (collectively, the Organization). All significant intercompany balances and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Income Taxes

GCH is a public charity under Section 501(c)(3) of the Internal Revenue Code. As a public charity, GCH is exempt from state and federal income taxes on income earned in accordance with its tax exempt purpose. Unrelated business income is subject to state and federal income tax. GBMHA is a nonexempt organization and files applicable Form 1120 (corporate return). No provision for income taxes was necessary for the years ended June 30, 2015 and 2014.

Management has evaluated the Organization's tax positions and concluded that the Organization has no unrelated business income or uncertain tax positions that require adjustment to the consolidated financial statements. The Organization is subject to U.S. federal and state examinations by tax authorities for years ended June 30, 2012 through June 30, 2015.

Cash and Cash Equivalents

Cash and cash equivalents consist of demand deposits and petty cash funds.

Investments

Investments consist of certificates of deposit with a maturity in excess of one year.

Patient Accounts Receivable

Patient accounts receivable are stated at the amount management expects to collect from outstanding balances. Patient accounts receivable are reduced by an allowance for uncollectible accounts. In evaluating the collectability of patient accounts receivable, the Organization analyzes its past history and identifies trends for each funding source. Management regularly reviews data about revenue in evaluating the sufficiency of the allowance for uncollectible accounts. Amounts not collected after all reasonable collection efforts have been exhausted are applied against the allowance for uncollectible accounts. The Organization has not changed its methodology for estimating the allowance for uncollectible accounts during 2015 or 2014.

A reconciliation of the allowance for uncollectible accounts at June 30 is as follows:

	2015	2014
Balance, beginning of year	$ 88,420	$ 137,852
Provision	255,044	304,004
Write-offs	(262,086)	(353,436)
Balance, end of year	$ 81,378	$ 88,420

Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed on the straight-line method.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted net assets, and excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as temporarily restricted net assets. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Organization has been limited by grantors or donors to a specific time-period or purpose. There were no temporarily restricted net assets at June 30, 2015 and 2014.

Permanently restricted net assets have been restricted by donors to be maintained by the Organization in perpetuity. There were no permanently restricted net assets at June 30, 2015 or 2014.

Patient Service Revenue

Patient service revenue is reported at the estimated net realizable amounts from patients, third-party payers, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payers. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

340B Drug Pricing Program

The Organization, as an FQHC, is eligible to participate in the 340B Drug Pricing Program. The program requires drug manufacturers to provide outpatient drugs to FQHC's and other identified entities at a reduced price. The Organization contracts with local pharmacies under this program. The local pharmacies dispense drugs to eligible patients of the Organization and bill Medicare and commercial insurances on behalf of the Organization. Reimbursement received by the pharmacies is remitted to the Organization, less dispensing and administrative fees. Gross revenue generated from the program is included in patient service revenue. Contracted expenses incurred related to the program are included in other operating expenses.

Charity Care

The Organization provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Organization does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenue.

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the consolidated statements of operations as "net assets released from restrictions." Donor-restricted contributions whose restrictions are met in the same year as received are reflected as unrestricted contributions in the accompanying consolidated financial statements.

Functional Expenses

The Organization provides various services to residents within its geographic location. Expenses related to providing these services are as follows:

	2015	2014
Program services	$ 6,330,133	$ 5,727,499
Administrative and general	1,154,848	1,050,293
Fundraising	180,836	137,934
Total	$ 7,665,817	$ 6,915,726

Excess of Revenues Over Expenses

The consolidated statements of operations reflect the excess of revenues over expenses. Changes in unrestricted net assets which are excluded from the excess of revenues over expenses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions which, by donor restriction, were to be used for the purposes of acquiring such assets).

Prior Period Adjustments

Grants and contributions received for capital acquisition previously placed in service and released over the life of the related assets from temporarily restricted net assets to unrestricted net assets were reclassified to unrestricted net assets as of the beginning of the year ended June 30, 2014. A contractual allowance reserve was established for the difference between amounts billed to third-party payers and expected payments for accounts receivable balances at June 30, 2014. Grants receivable and related revenue were increased for Outreach and Enrollment grant expenses incurred in June 2014. As a result of these adjustments, the following amounts previously reported have been restated as of June 30, 2014:

	Unrestricted Net Assets	Temporarily Restricted Net Assets
Balance as of June 30, 2014, as previously reported	$ 354,851	$ 5,419,981
Reverse net assets released from restriction for the year ended June 30, 2014	(210,011)	210,011
Reclassification of remaining balance of grants received for capital acquisition to unrestricted net assets	5,629,992	(5,629,992)
Record contractual allowance reserve	(47,857)	-
Record grant receivable	16,670	-
Total prior period adjustments	5,388,794	(5,419,981)
Balance as of June 30, 2014, as restated	$ 5,743,645	$ -

Subsequent Events

For purposes of the preparation of these financial statements, management has considered transactions or events occurring through December 11, 2015, the date that the financial statements were issued. Management has not evaluated subsequent events after that date for inclusion in the financial statements.

In September 2015, the Organization's Board of Directors voted to sell GBMHA to a local not-for-profit with an expected closing date of December 31, 2015.

The Organization has also received a commitment from Frisbie Memorial Hospital (holder of the Organization's line of credit) that the remaining balance on the line of credit will be forgiven in October 2015.

2. Fair Value of Financial Instruments

The following methods and assumptions were used by the Organization in estimating the fair value of certain financial instruments:

Cash and cash equivalents – The carrying amount reported in the consolidated balance sheet approximates fair value because of the short maturity of those instruments.

Investments - The carrying amount reported in the consolidated balance sheet approximates fair value because of the liquidity of the certificates of deposit.

Notes payable – The carrying amount reported in the consolidated balance sheets approximates fair value because the Organization can obtain similar loans at the same terms.

3. Property and Equipment

Property and equipment consisted of the following:

	2015	2014
Land	$ 718,427	$ 718,427
Building and improvements	5,670,162	5,670,162
Furniture, fixtures, and equipment	1,364,376	1,331,701
Total cost	7,752,965	7,720,290
Less accumulated depreciation	1,698,003	1,444,257
Total cost, less accumulated depreciation	6,054,962	6,276,033
Construction in progress	92,721	-
Property and equipment, net	$ 6,147,683	$ 6,276,033

The Organization's building was constructed with Federal grant funding under the American Recovery and Reinvestment Act (ARRA) – Facilities Improvement Program. In accordance with the grant agreements, a Notice of Federal Interest (NFI) is required to be filed in the appropriate official records of the jurisdiction in which the property is located. The NFI is designed to notify any prospective buyer or creditor that the Federal Government has a financial interest in the real property acquired under the aforementioned grant; that the property may not be used for any purpose inconsistent with that authorized by the grant program statute and applicable regulations; that the property may not be mortgaged or otherwise used as collateral without the written permission of the Associate Administrator of the Office of Federal Assistance Management, Health Resources and Services Administration (OFAM, HRSA); and that the property may not be sold or transferred to another party without the written permission of the Associate Administrator of OFAM, HRSA.

4. Line of Credit

The Organization has a $200,000 line of credit with Frisbie Memorial Hospital. The line of credit is interest free, unsecured, and due on demand. The outstanding balances on the line of credit at June 30, 2015 and 2014 were $56,500 and $193,500, respectively.

5. Long-term Debt

Long-term debt consists of the following:

	2015	2014
Variable rate note payable to a local bank, payable in monthly installments of $4,464, including interest at 4.75%, through December 2018, at which time the interest will be adjusted to the Federal Home Loan Bank of Boston Rate plus 2.5% and every five years thereafter through December 2029, collateralized by real estate which is subject to a Notice of Federal Interest (see Note 3).	$ 556,504	$ 584,049
Note payable to a not-for-profit corporation, payable in monthly installments of $8,069, including interest at 5.25%, through September 2017, collateralized by real estate which is subject to a Notice of Federal Interest (see Note 3) and all other assets.	205,217	288,858
Note payable to a local bank, payable in monthly installments of $1,860, including interest at 4.75%, through January 2019, collateralized by all assets.	73,251	90,112
Note payable, New Hampshire Health and Education Facilities Authority, payable in monthly installments of $1,709, including interest at 1.00%, through July 2016. The note is unsecured.	22,093	42,275

	2015	2014
Variable rate note payable to a local bank, payable in monthly installments of $596, including interest at Prime plus 1.5% with a 4% floor, currently at 4.75%, through June 2017, collateralized by all assets of GBMHA and an unlimited corporate guaranty of GCH.	12,956	19,307
Total long-term debt	870,021	1,024,601
Less current maturities	161,740	154,716
Long-term debt, less current maturities	$ 708,281	$ 869,885

The Organization is required to meet certain administrative and financial covenants under various loan agreements included above. The Organization is in compliance with all loan covenants at June 30, 2015.

Maturities of long-term debt for the next five years follows:

2016	$ 161,740
2017	150,098
2018	75,377
2019	42,728
2020	33,120

Cash paid for interest approximates interest expense.

6. Patient Service Revenue

Patient service revenue is as follows:

	2015	2014
Medicare	$ 638,547	$ 503,327
Medicaid	3,131,251	2,344,536
Third-party payers and private pay	2,131,634	1,902,460
Medical and dental patient service revenue	5,901,432	4,750,323
340B pharmacy revenue	244,614	-
Total patient service revenue	$ 6,146,046	$ 4,750,323

The Organization has agreements with the Centers for Medicare and Medicaid Services (Medicare) and New Hampshire Medicaid. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The management believes that the Organization is in compliance with all laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs. Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in patient service revenue in the year that such amounts become known.

A summary of the payment arrangements with major third-party payers follows:

Medicare

As an FQHC, the Organization is reimbursed for the care of qualified patients at specified interim contractual rates during the year. Differences between the Medicare interim contractual rate and the cost of care as defined by the Principles of Reimbursement governing the program are determined and settled on a retrospective basis. Overall, reimbursement is subject to a maximum allowable rate per visit. The Organization's Medicare cost reports have been audited by the Medicare administrative contractor through June 30, 2013.

Other Payers

The Organization also has entered into payment agreements with Medicaid and certain commercial insurance carriers, health maintenance organizations and preferred provider organizations. The basis for payment to the Organization under these agreements includes prospectively determined rates per visit, discounts from established charges and capitated arrangements for primary care services on a per member, per month basis.

The Organization provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. The Organization estimates the costs associated with providing charity care by calculating the ratio of total cost to total charges, and then multiplying that ratio by the gross uncompensated charges associated with providing care to patients eligible for free care. The estimated cost of providing services to patients under the Organization charity care policy amounted to approximately $486,000 and $680,000 for the years ended June 30, 2015 and 2014, respectively.

The Organization is able to provide these services with a component of funds received through local community support and federal and state grants.

7. Retirement Plan

The Organization has a defined contribution plan under Internal Revenue Code Section 401(k) that cover substantially all employees. In 2011, the Organization temporarily suspended the employer match.

8. WIC Food Vouchers

The Organization acts as a conduit for the State of New Hampshire's Special Supplemental Food Program for Women, Infants and Children (WIC). This program is funded by the U.S. Department of Agriculture (CFDA #10.565). The value of food vouchers distributed by the Organization was $1,570,536 and $1,572,910 for the years ended June 30, 2015 and 2014, respectively. These amounts are not included in the accompanying consolidated financial statements as they are not part of the contract the Organization has with the State of New Hampshire for the WIC program.

9. Concentration of Risk

The Organization has cash deposits in major financial institutions which exceed federal depository insurance limits. The financial institutions have a strong credit rating and management believes the credit risk related to these deposits is minimal.

The Organization grants credit without collateral to its patients, most of who are local residents and are insured under third-party payer agreements. At June 30, 2015 and 2014, Medicaid represented 31% and 30%, respectively, of gross accounts receivable. No other individual payer source exceeded 10% of the gross accounts receivable balance.

10. Commitments and Contingencies

Medical Malpractice Insurance

The Organization is protected from medical malpractice risk as an FQHC under the Federal Tort Claims Act (FTCA). As of June 30, 2015, there were no known malpractice claims outstanding which in the opinion of management, will be settled for amounts outside of FTCA coverage, nor are there any unasserted claims or incidents which require loss accrual.

GOODWIN COMMUNITY HEALTH AND SUBSIDIARIES

Consolidating Balance Sheet

June 30, 2015

ASSETS

	Goodwin Community Health	Great Bay Mental Health Associates	Eliminations	2015 Consolidated
Current assets				
Cash and cash equivalents	$ 1,632,421	$ 37,467	$ -	$ 1,669,888
Patient accounts receivable , net	553,922	103,801	(122,445)	535,278
Grants receivable	472,843	-	-	472,843
Other current assets	23,594	1,878	-	25,472
Total current assets	2,682,780	143,146	(122,445)	2,703,481
Investments	200,125	-	-	200,125
Property and equipment, net	6,145,032	2,651	-	6,147,683
Goodwill	45,000	-	(27,418)	17,582
Total assets	$ 9,072,937	$ 145,797	$ (149,863)	$ 9,068,871

LIABILITIES AND NET ASSETS (DEFICIT)

Current liabilities				
Line of credit	$ 56,500	$ -	$ -	$ 56,500
Accounts payable and accrued expenses	181,271	124,973	(122,445)	183,799
Accrued payroll and related expenses	358,224	75,256	-	433,480
Current portion of long-term debt	155,389	6,351	-	161,740
Total current liabilities	751,384	206,580	(122,445)	835,519
Long-term debt, less current maturities	701,676	6,605	-	708,281
Total liabilities	1,453,060	213,185	(122,445)	1,543,800
Net assets (deficit)				
Unrestricted	7,619,877	(67,388)	(27,418)	7,525,071
Total liabilities and net assets (deficit)	$ 9,072,937	$ 145,797	$ (149,863)	$ 9,068,871

GOODWIN COMMUNITY HEALTH AND SUBSIDIARIES

Consolidating Statement of Operations and Changes in Net Assets

Year Ended June 30, 2015

	Goodwin Community Health	Great Bay Mental Health Associates	Eliminations	2015 Consolidated
Operating revenue and support				
Patient service revenue	$ 5,322,573	$ 823,473	$ -	$ 6,146,046
Provision for bad debts	(256,074)	1,030	-	(255,044)
Net patient service revenue	5,066,499	824,503	-	5,891,002
Grant revenue	3,219,481	1,207	-	3,220,688
Other operating revenue	172,078	91,358	(53,280)	210,156
Total operating revenue and support	8,458,058	917,068	(53,280)	9,321,846
Operating expenses				
Salaries and benefits	5,182,403	732,415	-	5,914,818
Other operating expenses	1,365,911	139,200	(53,280)	1,451,831
Depreciation	252,522	1,221	-	253,743
Interest expense	45,167	258	-	45,425
Total operating expenses	6,846,003	873,094	(53,280)	7,665,817
Excess of revenues over expenses	1,612,055	43,974	-	1,656,029
Grants for capital acquisition	125,397	-	-	125,397
Increase in unrestricted net assets	1,737,452	43,974	-	1,781,426
Unrestricted net assets (deficit), beginning of year	5,882,425	(111,362)	(27,418)	5,743,645
Unrestricted net assets (deficit), end of year	$ 7,619,877	$ (67,388)	$ (27,418)	$ 7,525,071

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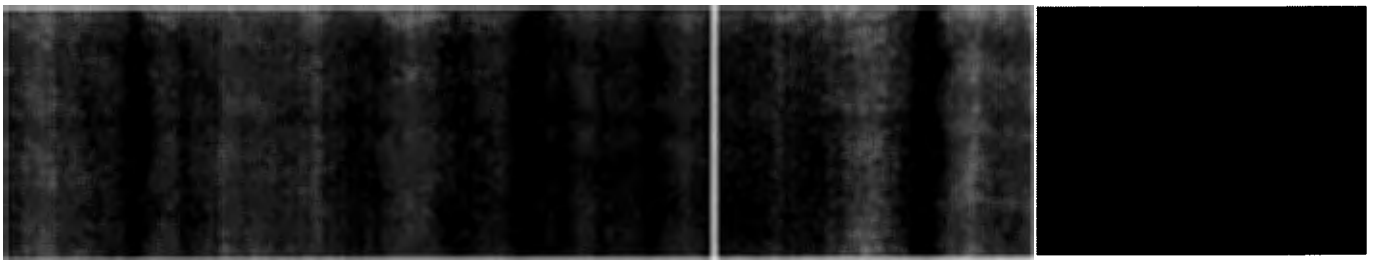

GOODWIN COMMUNITY HEALTH AND SUBSIDIARY

CONSOLIDATED FINANCIAL STATEMENTS

and

Supplementary Information and Government Reports in Accordance with OMB Circular A-133

June 30, 2015 and 2014

With Independent Auditor's Report

BerryDunn

INDEPENDENT AUDITOR'S REPORT

Board of Directors
Goodwin Community Health and Subsidiary

Report on Financial Statements

We have audited the accompanying consolidated financial statements of Goodwin Community Health and Subsidiary (the Organization), which comprise the consolidated balance sheet as of June 30, 2015, and the related consolidated statements of operations and changes in net assets and cash flows for the year then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We conducted our audit in accordance with U.S. generally accepted auditing standards and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Goodwin Community Health and Subsidiary as of June 30, 2015, and the results of their operations, changes in their net assets and their cash flows for the year then ended in accordance with U.S. generally accepted accounting principles.

Auditor's Updated Opinion on 2015 Consolidated Financial Statements

In our report dated October 15, 2015, we expressed an unmodified opinion that the 2015 consolidated financial statements. The 2015 consolidated financial statements have been revised to correct the amount of cash used by investing activities on the consolidated statement of cash flows. The auditor's opinion is not modified with respect to that matter.

Adjustments to Prior Period Summarized Comparative Information

The consolidated financial statements of the Organization as of June 30, 2014 were audited by another auditor whose opinion dated November 25, 2014, on those statements was unmodified. As disclosed in Note 1, the Organization has restated its 2014 consolidated financial statements during 2015 to change the classification of grants received for capital acquisition previously placed in service and released over the life of the related assets from temporarily restricted net assets to unrestricted net assets, to establish a contractual allowance reserve for the differences between amounts billed to third-party payers and amounts expected to be paid and to record additional grant funds receivable, in accordance with U.S. generally accepted accounting principles. The other auditor reported on the 2014 consolidated financial statements before the restatement.

As part of our audit of the 2015 consolidated financial statements, we also audited adjustments described in Note 1 that were applied to restate the accompanying 2014 consolidated financial statements. In our opinion, such adjustments are appropriate and have been properly applied. We were not engaged to audit, review or apply any procedures to the 2014consolidated financial statements of the Organization other than with respect to the adjustments and, accordingly, we do not express an opinion or any form of assurance on the 2014 consolidated financial statements as a whole.

Other Matters

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying supplementary consolidating statement of financial position as of June 30, 2015, and the related consolidating statements of operations and changes in net assets for the year then ended, is presented for purposes of additional analysis rather than to present the financial position and changes in net assets of the individual entities, and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from, and relates directly to, the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with U.S. generally accepted auditing standards. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by U.S. Office of Management and Budget Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations, and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with U.S. generally accepted auditing standards. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated December 11, 2015 on our consideration of Goodwin Community Health and Subsidiary's internal control over financial reporting and on our tests of their compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Goodwin Community Health and Subsidiary's internal control over financial reporting and compliance.

Berry Dunn McNeil & Parker, LLC

Concord, New Hampshire
December 11, 2015

GOODWIN COMMUNITY HEALTH AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2015 and 2014

ASSETS

	2015	Restated 2014
Current assets		
Cash and cash equivalents	$ 1,669,888	$ 655,579
Patient accounts receivable, less allowance for uncollectible accounts of $81,378 in 2015 and $88,420 in 2014	535,278	369,847
Grants receivable	472,843	162,610
Other current assets	25,472	17,145
Total current assets	2,703,481	1,205,181
Investments	200,125	-
Property and equipment, net	6,147,683	6,276,033
Goodwill	17,582	17,582
Other assets	-	8,010
Total assets	$ 9,068,871	$ 7,506,806

LIABILITIES AND NET ASSETS

Current liabilities		
Line of credit	$ 56,500	$ 193,500
Accounts payable and accrued expenses	183,799	181,237
Accrued payroll and related expenses	433,480	363,823
Current maturities of long-term debt	161,740	154,716
Total current liabilities	835,519	893,276
Long-term debt, less current maturities	708,281	869,885
Total liabilities	1,543,800	1,763,161
Net assets		
Unrestricted	7,525,071	5,743,645
Total liabilities and net assets	$ 9,068,871	$ 7,506,806

The accompanying notes are an integral part of these consolidated financial statements.

GOODWIN COMMUNITY HEALTH AND SUBSIDIARIES

Consolidated Statements of Operations and Changes in Net Assets

Years Ended June 30, 2015 and 2014

	2015	Restated 2014
Operating revenue and support		
Patient service revenue	**$ 6,146,046**	$ 4,750,323
Provision for bad debts	**(255,044)**	(304,004)
Net patient service revenue	**5,891,002**	4,446,319
Grants, contracts, and contributions	**3,220,688**	2,492,463
Other operating revenue	**210,156**	164,404
Total operating revenue and support	**9,321,846**	7,103,186
Operating expenses		
Salaries and benefits	**5,914,818**	5,302,071
Other operating expenses	**1,451,831**	1,284,577
Depreciation	**253,743**	271,833
Interest expense	**45,425**	57,245
Total operating expenses	**7,665,817**	6,915,726
Excess of revenues over expenses	**1,656,029**	187,460
Grants for capital acquisition	**125,397**	-
Increase in unrestricted net assets	**1,781,426**	187,460
Unrestricted net assets, beginning of year	**5,743,645**	5,556,185
Unrestricted net assets, end of year	**$ 7,525,071**	$ 5,743,645

The accompanying notes are an integral part of these consolidated financial statements.

GOODWIN COMMUNITY HEALTH AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years Ended June 30, 2015 and 2014

	2015	Restated 2014
Cash flows from operating activities		
Change in net assets	**$ 1,781,426**	$ 187,460
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Provision for bad debts	**255,044**	304,004
Depreciation	**253,743**	271,833
Grants for capital acquisition	**(125,397)**	-
Debt forgiveness	**(25,000)**	-
(Increase) decrease in		
Patient accounts receivable	**(420,475)**	(443,911)
Grants receivable	**(310,233)**	(54,428)
Other assets	**(317)**	15,012
Increase (decrease) in		
Accounts payable and accrued expenses	**2,562**	(79,493)
Accrued salaries and related amounts	**69,657**	43,051
Net cash provided by operating activities	**1,481,010**	243,528
Cash flows from investing activities		
Capital acquisitions	**(125,393)**	-
Purchase of investments	**(200,125)**	-
Net cash used by investing activities	**(325,518)**	-
Cash flows from financing activities		
Grants for capital acquisition	**125,397**	-
Payments on long-term debt	**(154,580)**	(137,656)
Proceeds from long-term debt	**-**	99,000
Payments on line of credit	**(112,000)**	(133,780)
Net cash used by financing activities	**(141,183)**	(172,436)
Net increase in cash and cash equivalents	**1,014,309**	71,092
Cash and cash equivalents, beginning of year	**655,579**	584,487
Cash and cash equivalents, end of year	**$ 1,669,888**	$ 655,579
Supplemental disclosures of cash flow information:		
Cash paid for interest	$ 57,245	$ 57,245
Noncash transaction - debt forgiveness	25,000	-

The accompanying notes are an integral part of these consolidated financial statements.

Organization

Goodwin Community Health (GCH) is a non-stock, not-for-profit corporation organized in New Hampshire. GCH is a Federally Qualified Health Center (FQHC) which provides prenatal care, social support, and public health services to low-income persons.

Subsidiary

Great Bay Mental Health Associates, Inc. (GBMHA), a wholly-owned for-profit subsidiary, engaged in providing mental health services in the Strafford County, New Hampshire community through its employees and independent contractors who are qualified and licensed to practice in the State of New Hampshire.

1. Summary of Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements include the accounts of GCH and its subsidiary, GBMHA (collectively, the Organization). All significant intercompany balances and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Income Taxes

GCH is a public charity under Section 501(c)(3) of the Internal Revenue Code. As a public charity, GCH is exempt from state and federal income taxes on income earned in accordance with its tax exempt purpose. Unrelated business income is subject to state and federal income tax. GBMHA is a nonexempt organization and files applicable Form 1120 (corporate return). No provision for income taxes was necessary for the years ended June 30, 2015 and 2014.

Management has evaluated the Organization's tax positions and concluded that the Organization has no unrelated business income or uncertain tax positions that require adjustment to the consolidated financial statements. The Organization is subject to U.S. federal and state examinations by tax authorities for years ended June 30, 2012 through June 30, 2015.

Cash and Cash Equivalents

Cash and cash equivalents consist of demand deposits and petty cash funds.

Investments

Investments consist of certificates of deposit with a maturity in excess of one year.

Patient Accounts Receivable

Patient accounts receivable are stated at the amount management expects to collect from outstanding balances. Patient accounts receivable are reduced by an allowance for uncollectible accounts. In evaluating the collectability of patient accounts receivable, the Organization analyzes its past history and identifies trends for each funding source. Management regularly reviews data about revenue in evaluating the sufficiency of the allowance for uncollectible accounts. Amounts not collected after all reasonable collection efforts have been exhausted are applied against the allowance for uncollectible accounts. The Organization has not changed its methodology for estimating the allowance for uncollectible accounts during 2015 or 2014.

A reconciliation of the allowance for uncollectible accounts at June 30 is as follows:

	2015	2014
Balance, beginning of year	$ 88,420	$ 137,852
Provision	255,044	304,004
Write-offs	(262,086)	(353,436)
Balance, end of year	$ 81,378	$ 88,420

Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed on the straight-line method.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted net assets, and excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as temporarily restricted net assets. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Organization has been limited by grantors or donors to a specific time-period or purpose. There were no temporarily restricted net assets at June 30, 2015 and 2014.

Permanently restricted net assets have been restricted by donors to be maintained by the Organization in perpetuity. There were no permanently restricted net assets at June 30, 2015 or 2014.

Patient Service Revenue

Patient service revenue is reported at the estimated net realizable amounts from patients, third-party payers, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payers. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

340B Drug Pricing Program

The Organization, as an FQHC, is eligible to participate in the 340B Drug Pricing Program. The program requires drug manufacturers to provide outpatient drugs to FQHC's and other identified entities at a reduced price. The Organization contracts with local pharmacies under this program. The local pharmacies dispense drugs to eligible patients of the Organization and bill Medicare and commercial insurances on behalf of the Organization. Reimbursement received by the pharmacies is remitted to the Organization, less dispensing and administrative fees. Gross revenue generated from the program is included in patient service revenue. Contracted expenses incurred related to the program are included in other operating expenses.

Charity Care

The Organization provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Organization does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenue.

Donor-Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the consolidated statements of operations as "net assets released from restrictions." Donor-restricted contributions whose restrictions are met in the same year as received are reflected as unrestricted contributions in the accompanying consolidated financial statements.

Functional Expenses

The Organization provides various services to residents within its geographic location. Expenses related to providing these services are as follows:

	2015	2014
Program services	$ 6,330,133	$ 5,727,499
Administrative and general	1,154,848	1,050,293
Fundraising	180,836	137,934
Total	$ 7,665,817	$ 6,915,726

Excess of Revenues Over Expenses

The consolidated statements of operations reflect the excess of revenues over expenses. Changes in unrestricted net assets which are excluded from the excess of revenues over expenses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions which, by donor restriction, were to be used for the purposes of acquiring such assets).

Prior Period Adjustments

Grants and contributions received for capital acquisition previously placed in service and released over the life of the related assets from temporarily restricted net assets to unrestricted net assets were reclassified to unrestricted net assets as of the beginning of the year ended June 30, 2014. A contractual allowance reserve was established for the difference between amounts billed to third-party payers and expected payments for accounts receivable balances at June 30, 2014. Grants receivable and related revenue were increased for Outreach and Enrollment grant expenses incurred in June 2014. As a result of these adjustments, the following amounts previously reported have been restated as of June 30, 2014:

	Unrestricted Net Assets	Temporarily Restricted Net Assets
Balance as of June 30, 2014, as previously reported	$ 354,851	$ 5,419,981
Reverse net assets released from restriction for the year ended June 30, 2014	(210,011)	210,011
Reclassification of remaining balance of grants received for capital acquisition to unrestricted net assets	5,629,992	(5,629,992)
Record contractual allowance reserve	(47,857)	-
Record grant receivable	16,670	-
Total prior period adjustments	5,388,794	(5,419,981)
Balance as of June 30, 2014, as restated	$ 5,743,645	$ -

Subsequent Events

For purposes of the preparation of these financial statements, management has considered transactions or events occurring through December 11, 2015, the date that the financial statements were issued. Management has not evaluated subsequent events after that date for inclusion in the financial statements.

In September 2015, the Organization's Board of Directors voted to sell GBMHA to a local not-for-profit with an expected closing date of December 31, 2015.

The Organization has also received a commitment from Frisbie Memorial Hospital (holder of the Organization's line of credit) that the remaining balance on the line of credit will be forgiven in October 2015.

2. Fair Value of Financial Instruments

The following methods and assumptions were used by the Organization in estimating the fair value of certain financial instruments:

Cash and cash equivalents – The carrying amount reported in the consolidated balance sheet approximates fair value because of the short maturity of those instruments.

Investments - The carrying amount reported in the consolidated balance sheet approximates fair value because of the liquidity of the certificates of deposit.

Notes payable – The carrying amount reported in the consolidated balance sheets approximates fair value because the Organization can obtain similar loans at the same terms.

3. Property and Equipment

Property and equipment consisted of the following:

	2015	2014
Land	$ 718,427	$ 718,427
Building and improvements	5,670,162	5,670,162
Furniture, fixtures, and equipment	1,364,376	1,331,701
Total cost	7,752,965	7,720,290
Less accumulated depreciation	1,698,003	1,444,257
Total cost, less accumulated depreciation	6,054,962	6,276,033
Construction in progress	92,721	-
Property and equipment, net	$ 6,147,683	$ 6,276,033

The Organization's building was constructed with Federal grant funding under the American Recovery and Reinvestment Act (ARRA) – Facilities Improvement Program. In accordance with the grant agreements, a Notice of Federal Interest (NFI) is required to be filed in the appropriate official records of the jurisdiction in which the property is located. The NFI is designed to notify any prospective buyer or creditor that the Federal Government has a financial interest in the real property acquired under the aforementioned grant; that the property may not be used for any purpose inconsistent with that authorized by the grant program statute and applicable regulations; that the property may not be mortgaged or otherwise used as collateral without the written permission of the Associate Administrator of the Office of Federal Assistance Management, Health Resources and Services Administration (OFAM, HRSA); and that the property may not be sold or transferred to another party without the written permission of the Associate Administrator of OFAM, HRSA.

4. Line of Credit

The Organization has a $200,000 line of credit with Frisbie Memorial Hospital. The line of credit is interest free, unsecured, and due on demand. The outstanding balances on the line of credit at June 30, 2015 and 2014 were $56,500 and $193,500, respectively.

5. Long-term Debt

Long-term debt consists of the following:

	2015	2014
Variable rate note payable to a local bank, payable in monthly installments of $4,464, including interest at 4.75%, through December 2018, at which time the interest will be adjusted to the Federal Home Loan Bank of Boston Rate plus 2.5% and every five years thereafter through December 2029, collateralized by real estate which is subject to a Notice of Federal Interest (see Note 3).	$ 556,504	$ 584,049
Note payable to a not-for-profit corporation, payable in monthly installments of $8,069, including interest at 5.25%, through September 2017, collateralized by real estate which is subject to a Notice of Federal Interest (see Note 3) and all other assets.	205,217	288,858
Note payable to a local bank, payable in monthly installments of $1,860, including interest at 4.75%, through January 2019, collateralized by all assets.	73,251	90,112
Note payable, New Hampshire Health and Education Facilities Authority, payable in monthly installments of $1,709, including interest at 1.00%, through July 2016. The note is unsecured.	22,093	42,275

	2015	2014
Variable rate note payable to a local bank, payable in monthly installments of $596, including interest at Prime plus 1.5% with a 4% floor, currently at 4.75%, through June 2017, collateralized by all assets of GBMHA and an unlimited corporate guaranty of GCH.	12,956	19,307
Total long-term debt	870,021	1,024,601
Less current maturities	161,740	154,716
Long-term debt, less current maturities	$ 708,281	$ 869,885

The Organization is required to meet certain administrative and financial covenants under various loan agreements included above. The Organization is in compliance with all loan covenants at June 30, 2015.

Maturities of long-term debt for the next five years follows:

2016	$ 161,740
2017	150,098
2018	75,377
2019	42,728
2020	33,120

Cash paid for interest approximates interest expense.

6. Patient Service Revenue

Patient service revenue is as follows:

	2015	2014
Medicare	$ 638,547	$ 503,327
Medicaid	3,131,251	2,344,536
Third-party payers and private pay	2,131,634	1,902,460
Medical and dental patient service revenue	5,901,432	4,750,323
340B pharmacy revenue	244,614	-
Total patient service revenue	$ 6,146,046	$ 4,750,323

The Organization has agreements with the Centers for Medicare and Medicaid Services (Medicare) and New Hampshire Medicaid. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The management believes that the Organization is in compliance with all laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs. Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in patient service revenue in the year that such amounts become known.

A summary of the payment arrangements with major third-party payers follows:

Medicare

As an FQHC, the Organization is reimbursed for the care of qualified patients at specified interim contractual rates during the year. Differences between the Medicare interim contractual rate and the cost of care as defined by the Principles of Reimbursement governing the program are determined and settled on a retrospective basis. Overall, reimbursement is subject to a maximum allowable rate per visit. The Organization's Medicare cost reports have been audited by the Medicare administrative contractor through June 30, 2013.

Other Payers

The Organization also has entered into payment agreements with Medicaid and certain commercial insurance carriers, health maintenance organizations and preferred provider organizations. The basis for payment to the Organization under these agreements includes prospectively determined rates per visit, discounts from established charges and capitated arrangements for primary care services on a per member, per month basis.

The Organization provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. The Organization estimates the costs associated with providing charity care by calculating the ratio of total cost to total charges, and then multiplying that ratio by the gross uncompensated charges associated with providing care to patients eligible for free care. The estimated cost of providing services to patients under the Organization charity care policy amounted to approximately $486,000 and $680,000 for the years ended June 30, 2015 and 2014, respectively.

The Organization is able to provide these services with a component of funds received through local community support and federal and state grants.

7. Retirement Plan

The Organization has a defined contribution plan under Internal Revenue Code Section 401(k) that cover substantially all employees. In 2011, the Organization temporarily suspended the employer match.

8. WIC Food Vouchers

The Organization acts as a conduit for the State of New Hampshire's Special Supplemental Food Program for Women, Infants and Children (WIC). This program is funded by the U.S. Department of Agriculture (CFDA #10.565). The value of food vouchers distributed by the Organization was $1,570,536 and $1,572,910 for the years ended June 30, 2015 and 2014, respectively. These amounts are not included in the accompanying consolidated financial statements as they are not part of the contract the Organization has with the State of New Hampshire for the WIC program.

9. Concentration of Risk

The Organization has cash deposits in major financial institutions which exceed federal depository insurance limits. The financial institutions have a strong credit rating and management believes the credit risk related to these deposits is minimal.

The Organization grants credit without collateral to its patients, most of who are local residents and are insured under third-party payer agreements. At June 30, 2015 and 2014, Medicaid represented 31% and 30%, respectively, of gross accounts receivable. No other individual payer source exceeded 10% of the gross accounts receivable balance.

10. Commitments and Contingencies

Medical Malpractice Insurance

The Organization is protected from medical malpractice risk as an FQHC under the Federal Tort Claims Act (FTCA). As of June 30, 2015, there were no known malpractice claims outstanding which in the opinion of management, will be settled for amounts outside of FTCA coverage, nor are there any unasserted claims or incidents which require loss accrual.

GOODWIN COMMUNITY HEALTH AND SUBSIDIARIES

Consolidating Balance Sheet

June 30, 2015

ASSETS

	Goodwin Community Health	Great Bay Mental Health Associates	Eliminations	2015 Consolidated
Current assets				
Cash and cash equivalents	$ 1,632,421	$ 37,467	$ -	$ 1,669,888
Patient accounts receivable , net	553,922	103,801	(122,445)	535,278
Grants receivable	472,843	-	-	472,843
Other current assets	23,594	1,878	-	25,472
Total current assets	2,682,780	143,146	(122,445)	2,703,481
Investments	200,125	-	-	200,125
Property and equipment, net	6,145,032	2,651	-	6,147,683
Goodwill	45,000	-	(27,418)	17,582
Total assets	$ 9,072,937	$ 145,797	$ (149,863)	$ 9,068,871

LIABILITIES AND NET ASSETS (DEFICIT)

Current liabilities				
Line of credit	$ 56,500	$ -	$ -	$ 56,500
Accounts payable and accrued expenses	181,271	124,973	(122,445)	183,799
Accrued payroll and related expenses	358,224	75,256	-	433,480
Current portion of long-term debt	155,389	6,351	-	161,740
Total current liabilities	751,384	206,580	(122,445)	835,519
Long-term debt, less current maturities	701,676	6,605	-	708,281
Total liabilities	1,453,060	213,185	(122,445)	1,543,800
Net assets (deficit)				
Unrestricted	7,619,877	(67,388)	(27,418)	7,525,071
Total liabilities and net assets (deficit)	$ 9,072,937	$ 145,797	$ (149,863)	$ 9,068,871

GOODWIN COMMUNITY HEALTH AND SUBSIDIARIES

Consolidating Statement of Operations and Changes in Net Assets

Year Ended June 30, 2015

	Goodwin Community Health	Great Bay Mental Health Associates	Eliminations	2015 Consolidated
Operating revenue and support				
Patient service revenue	$ 5,322,573	$ 823,473	$ -	$ 6,146,046
Provision for bad debts	(256,074)	1,030	-	(255,044)
Net patient service revenue	5,066,499	824,503	-	5,891,002
Grant revenue	3,219,481	1,207	-	3,220,688
Other operating revenue	172,078	91,358	(53,280)	210,156
Total operating revenue and support	8,458,058	917,068	(53,280)	9,321,846
Operating expenses				
Salaries and benefits	5,182,403	732,415	-	5,914,818
Other operating expenses	1,365,911	139,200	(53,280)	1,451,831
Depreciation	252,522	1,221	-	253,743
Interest expense	45,167	258	-	45,425
Total operating expenses	6,846,003	873,094	(53,280)	7,665,817
Excess of revenues over expenses	1,612,055	43,974	-	1,656,029
Grants for capital acquisition	125,397	-	-	125,397
Increase in unrestricted net assets	1,737,452	43,974	-	1,781,426
Unrestricted net assets (deficit), beginning of year	5,882,425	(111,362)	(27,418)	5,743,645
Unrestricted net assets (deficit), end of year	$ 7,619,877	$ (67,388)	$ (27,418)	$ 7,525,071

SUPPLEMENTARY INFORMATION

GOODWIN COMMUNITY HEALTH AND SUBSIDARY

Schedule of Expenditures of Federal Awards

Year Ended June 30, 2015

Federal Grant/Pass-Through Grantor/Program Title	Federal CFDA Number	Passthrough Contract Number	Total Federal Expenditures
United States Department of Health and Human Services:			
Direct:			
Health Centers Cluster			
Consolidated Health Centers	93.224		$ 356,270
Affordable Care Act (ACA) Grants for Capital Development in Health Centers	93.526		92,721
Affordable Care Act (ACA) Grants for New and Expanded Services Under the Health Center Program	93.527		951,240
Total Health Centers Cluster			1,400,231
Passthrough:			
State of New Hampshire Department of Health and Human Services			
Breast and Cervical Cancer Prevention	93.283	102-500731 / 90080081	45,879
Community Health Access Network, Inc.			
Chronic Disease Prevention Asthma	93.283		13,346
Diabetes	93.283		700
Total			59,925
State of New Hampshire Department of Health and Human Services			
Public Health Block Grant	93.959	102-500734 / 49156501	7,737
Substance Misuse	93.959	102-500734 / 49156501	71,160
Total			78,897
Public Health Preparedness	93.074	102-500734 / 49156501	62,400
Family Planning	93.217	102-500734 / 90080203	46,262
Immunization School based clinics	93.268	102-500734 / 49156501	8,987
Family Planning - TANF	93.558	502-500891 / 45130203	13,318
Block Grants for Prevention and Treatment of Substance Abuse	93.758	102-500734 / 49156501	38,925
Oral Health	93.991	102-500731 / 90072003	21,325
Primary Care	93.994	102-500731 / 90080000	24,960

GOODWIN COMMUNITY HEALTH AND SUBSIDARY

Schedule of Expenditures of Federal Awards (Concluded)

Year Ended June 30, 2015

Federal Grant/Pass-Through Grantor/Program Title	Federal CFDA Number	Passthrough Contract Number	Total Federal Expenditures
United States Department of Health and Human Services:			
Passthrough:			
Bi-State Primary Care Association			
Cooperative Agreement to Support Navigators in Federally-Facilitated and State Partnership Marketplaces	93.332		22,866
Total United States Department of Health and Human Services			1,778,096
United States Department of Agriculture:			
Passthrough:			
State of New Hampshire Department of Health and Human Services			
WIC, Commodity Supplemental Food, and Breastfeeding Peer Counseling Programs	10.557	102-500743	463,212
Total Federal Awards, All Programs			$ 2,241,308

The accompanying notes are an integral part of this schedule.

GOODWIN COMMUNITY HEALTH AND SUBSIDIARY

Notes to Schedule of Expenditures of Federal Awards

Year Ended June 30, 2015

1. **Basis of Presentation**

The schedule of expenditures of federal awards includes the federal grant activity of Goodwin Community Health and Subsidiary. The information in this Schedule is presented in accordance with the requirements of U.S. Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations.* Because the schedule presents only a selected portion of the operations of the Association, it is not intended to, and does not present, the consolidated financial position, changes in net assets, or cash flows of Goodwin Community Health and Subsidiary.

2. **Summary of Significant Accounting Policies**

Expenditures reported on the schedule are reported on the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in OMB Circular A-122, *Cost Principles for Nonprofit Organizations*, wherein certain types of expenditures are not allowable or are limited as to reimbursement.

Negative amounts shown on the schedule, if applicable, represent adjustments or credits made in the normal course of business to amounts reported as expenditures in prior years. Pass-through entity identifying numbers are presented where available.

SCHEDULE AND REPORTS IN ACCORDANCE WITH *GAS*, OMB CIRCULAR A-133

BerryDunn

INDEPENDENT AUDITOR'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Board of Directors
Goodwin Community Health and Subsidiary

We have audited, in accordance with U.S. generally accepted auditing standards and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Goodwin Community Health and Subsidiary, which comprise the consolidated balance sheet as of June 30, 2015, and the related consolidated statements of operations and changes in net assets and cash flows for the year then ended, and the related notes to the consolidated financial statements, and have issued our report thereon dated December 11, 2015.

Internal Control over Financial Reporting

In planning and performing our audit of the consolidated financial statements, we considered the Organization's internal control over financial reporting (internal control) to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control. Accordingly, we do not express an opinion on the effectiveness of the Organization's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's consolidated financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Board of Directors
Goodwin Community Health and Subsidiary

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Organization's consolidated financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Organization's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Organization's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Berry Dunn McNeil & Parker, LLC

Concord, New Hampshire
December 11, 2015

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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE FOR THE MAJOR FEDERAL PROGRAM AND REPORT ON INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY OMB CIRCULAR A-133

Board of Directors
Goodwin Community Health and Subsidiary

Report on Compliance for the Major Federal Program

We have audited Goodwin Community Health and Subsidiary's compliance with the types of compliance requirements described in the *OMB Circular A-133 Compliance Supplement* that could have a direct and material effect on its major federal program for the year ended June 30, 2015. The Organization's major federal program is identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to its federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for the Organization's major federal program based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with U.S. generally accepted auditing standards; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the Organization's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for the major federal program. However, our audit does not provide a legal determination of the Organization's compliance.

Opinion on the Major Federal Program

In our opinion, the Organization complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on its major federal program for the year ended June 30, 2015.

Board of Directors
Goodwin Community Health and Subsidiary

Report on Internal Control over Compliance

Management of the Organization is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit, we considered the Organization's internal control over compliance with the types of requirements that could have a direct and material effect on the major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing our opinion on compliance for the major federal program and to test and report on internal control over compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Organization's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of OMB Circular A-133. Accordingly, this report is not suitable for any other purpose.

Berry Dunn McNeil & Parker, LLC

Concord, New Hampshire
December 11, 2015

GOODWIN COMMUNITY HEALTH AND SUBSIDIARY

Schedule of Findings and Questioned Costs

Year Ended June 30, 2015

1. **Summary of Auditor's Results**

Financial Statements

Type of auditor's report issued:				Unmodified
Internal control over financial reporting:				
Material weakness(es) identified?	☐	Yes	☑	No
Significant deficiency(ies) identified that are not considered to be material weakness(es)?	☐	Yes	☑	None reported
Noncompliance material to financial statements noted?	☐	Yes	☑	No

Federal Awards

Internal control over major programs:				
Material weakness(es) identified:	☐	Yes	☑	No
Significant deficiency(ies) identified that are not considered to be material weakness(es)?	☐	Yes	☑	None reported
Type of auditor's report issued on compliance for major programs:				Unmodified
Any audit findings disclosed that are required to be reported in accordance with Section 510(a) of Circular A-133?	☐	Yes	☑	No

Identification of major programs:

Name of Federal Program or Cluster	CFDA Number
Health Centers Cluster	
Consolidated Health Centers	93.224
Affordable Care Act (ACA) Grants for Capital Development in Health Centers	93.526
Affordable Care Act (ACA) Grants for New and Expanded Services Under the Health Center Program	93.527

Dollar threshold used to distinguish between Type A and Type B programs:				$300,000
Auditee qualified as low-risk auditee?	☑	Yes	☐	No

GOODWIN COMMUNITY HEALTH AND SUBSIDIARY

Schedule of Findings and Questioned Costs (Concluded)

Year Ended June 30, 2015

2. Financial Statement Findings

None

3. Federal Award Findings and Questioned Costs

None

Goodwin
Community Health

Board of Directors
Fiscal Year 2016

Name/Address	Phone/Email	Occupation
Chair David B. Staples, DDS		Dentist **Consumer**
Vice Chair Valerie Goodwin [redacted]		Business **Consumer**
Board Treasurer Mark Boulanger [redacted]		CPA
Board Secretary Jennifer Glidden		DHHS Admin. Supervisor **Consumer**
Don Chick [redacted]	[redacted]om	Photographer **Consumer**
Stacie Collucci [redacted]	[redacted]	Interim Healthcare Account Executive **Consumer**
Whitney Galeucia [redacted]	[redacted]	**Consumer**
Lisa Hall [redacted]	[redacted]	Retired Accountant
Allyson Hicks [redacted]	[redacted]	Hospital Finance Director
Robert F. Kraunz, MD [redacted]	[redacted]	Retired Physician
Mathurin Malby, MD [redacted]	[redacted]	Physician
Allison Neal [redacted]	[redacted]	Education Consultant **Consumer**

Rev. 4/2016

Name/Address	Phone/Email	Occupation
Marissa Ruffini Scott [redacted]	[redacted]	Music Therapist **Consumer**
Jeffrey Segil, MD [redacted]	[redacted]	Physician-OB/GYN
Eric Tolbert Kilchenstein Shaheen & Gordon, P.A. [redacted]	[redacted]	Attorney

JANET MARIE LAATSCH

[redacted]

Professional Health Care Administrator with years of leadership experience in operations, finance and development.

SUMMARY OF SKILLS

*Budget Development and Management * Financial projections * Grant Writing * Development*
*Strategic Planning * Relationship Building * Patient Satisfaction*
*Quality Improvement * Provider Recruitment and Retention*

PROFESSIONAL EXPERIENCE

Goodwin Community Health, Somersworth, NH –An Innovative Federally Qualified Health Center with an integrated health care model quoted by the Commissioner as the 'model of the future' for NH.

Executive Director 2005-Present

- Created an innovative, affordable health care program for small-medium businesses
- Created strategic partnerships and collaborative programs with other health care organizations
- Advanced the Health Center by receiving $5.8M in grant funding for a new building
- Merged three locations into one, reduced costs and improved access
- Secured over $25M in grant funding since 2001
- Initiated and integrated behavioral and primary care
- Realized revenue growth through increased collections
- Performed ongoing Board development
- Acquired a for-profit mental health practice
- Successful recruitment and retention of providers
- Submitted and awarded NCQA Medical Home, Level III Certification
- Demonstrated improvements in patient outcomes and satisfaction

CEO Great Bay Mental Health Associates 2012-Present

- Recruited seven new therapist/prescribers
- Recognized a surplus for the first time in 12 months

Finance Director 2003-2005

- Awarded Federally Qualified Health Center grant in 2004-$750,000 in perpetuity
- Additional grant award for $150,000 to expand into behavioral health
- Obtained $450,000 in grants to initiate the oral health program
- Ended each year with a surplus
- Successful integration of oral health and primary care

Fund Development 2001-2003

- 80% success rate for grants
- Successful annual appeals

Grant Writing Services, 1999-2001
N. Hampton, NH
Sole Proprietor

- Successfully wrote and received grants for health care organizations and education

- Development of a business plan for a local specialist practice.

North Shore Medical Center (Partners Health Care) 1998-1999
Salem, MA
Consultant for North Shore Community Health Center

- Hired for a year to improve cash flow and operations
- Successfully ended up with a surplus
- Recruitment of a Medical Director, and other providers
- Successful obtained state and federal funding to support the Health Center

Director of Nursing for ambulatory and emergency care 1993-1998

- Co-Chair of the Nursing Quality Improvement Committee
- Increased revenue per visit in the emergency room
- Successfully prepared new clinics for licensure and accreditation
- Community Benefit liaison for the hospital
- Co-Chair of the Community Health Network for the North Shore Hospital
- Obtained several awards from Partners Health Care for Community Leadership

Manager of Intermediate Cardiac Care and Telemetry Unit 1991-1993

- Reduction in length of stay by 1.5 days
- Development of a new 24 hour observation unit for patients with chest pain
- Increased skill level of nursing staff to reduce cardiac care length of stay
- Implementation of new patient care models to reduce the cost of care

Registered Nurse- Various positions as a RN including ICU, ER, Boston Visiting Nurse Assoc. 1981-1991

EDUCATION:

University of New Hampshire: M.B.A. Graduated
Durham, N.H. Concentration in Finance 1991

Northern Michigan University: B.S.N.
Marquette, M.I. Minor in Biology 1981

VOLUNTEER ACTIVITIES:
Rochester NH Rotary Member and Past President
Board member Community Health Access Network
Board member for Bi-State Primary Care Association
Past United Way of the Greater Seacoast Board Member

LICENSES:
N.H. Real Estate Broker
N.H. Nursing License

INTERESTS/PERSONAL:
Running, hiking, reading, leadership development

Susan M. Gordon

[redacted]

OBJECTIVE

Experienced, licensed, clinical social worker and substance misuse counselor, working in integrated health care in a primary care setting, seeking opportunity as adjunct teaching instructor in a Masters Level Social Work Program

EDUCATIONAL BACKGROUND

Master Licensed Alcohol and Drug Counselor, NH #875,
1/2012
Independent Clinical Social Worker, NH #1675, 9/1/2012
Bachelor of Arts in Social Work, Cum Laude, UNH, 5/2008
Master in Social Work, Advanced Standing, UNH, 5/2010

PROFESSIONAL EXPERIENCE

MSW Advanced Clinical Work - 2009 - 2010 / ACT (Assertive Community Treatment) in Child, Adolescent and Adult ACT Programs at Counseling Services Inc., Kittery, ME

- Provided 1: 1 clinical and therapeutic interventions for individuals and families needing mental
  health and crisis stabilization, in home, school and office settings
- Collaborated with clients to formulate their treatment plan goals
- Provided a valuable link to community resources for individuals and their families
- Worked as part of an clinical team with a comprehensive approach to mental health services

Krempels Brain- Injury Foundation in Portsmouth, NH, BSW intern, 2007-2008

- Facilitated support groups for survivors of traumatic brain injury and their caregivers
- Provided 1: 1 support and case management services to survivors of TBI and their families
- Worked closely with other professionals as part of an interdisciplinary approach to treating survivors of TBI
- Reviewed grant applications to insure that criteria for funding approval was met
- Advocated for TBI survivors and their families on a community level

Crossroads House Shelter for the Homeless, Portsmouth, NH, BSW Intern, 1997

- Conducted intake interviews and assessments of individuals and families in need of emergency shelter
- Provided support and guidance to individuals and families in crisis and assisted them in their transition process

PROFESSIONAL WORK EXPERIENCE

Director of Behavioral Health Services – Goodwin Community Health Center 1/2016-present

- Provides psychological assessment and psychotherapy to patients
- Oversees the Intensive Outpatient Program and Medication Assistance Therapy in conjunction with designated medical provider
- Supervises staff of above two programs, along with other BH therapists
- Reviews behavioral health data and participates in project charters with behavioral health component
- Facilitates monthly behavioral health meetings
- Assists with risk management activities
- Assists Human Resources with recruitment and retention
- Policy development and updates for clinical and administration procedures

Adjunct faculty position - University of New Hampshire – Masters of Social Work Program 9/15-12/15

Behavioral Health Therapist – Goodwin Community Health Center, Somersworth, NH, 10/ 2013-present

- Collaborate with other health care staff on patient treatment plans
- Participate in design and implementation of integrated health care protocols
- Complete clinical documentation
- Attend and participate in meetings as deemed necessary
- Consult with other staff re: patient mental health needs
- Participate in and conduct educational in-service trainings
- Assess patient needs for community resources
- Focus on methods and skills dealing with patient's mental health issues

Therapist in Integrated Care at Wentworth Health Partners, Dover, NH 5/2014-10/ 2014 (contract between GBMHA and WDH)

- Conducted intake assessments
- Provided individual, couples and family therapy
- Participated in clinical peer supervision
- Provide Licensed Alcohol and Drug Assessments
- Collaborated with providers and other community professional regarding patient care

Outpatient Therapist - Great Bay Mental Health Associates, Somersworth, NH, 8/2013 – 10/2014

- Conducted intake assessments
- Provided individual, couples and family therapy
- Participated in clinical peer supervision
- Provide Licensed Alcohol and Drug Assessments
- Collaborated with other community professionals about patient care

Therapist in Intensive Outpatient Program for Co-occurring Substance Abuse and Mental

Health Disorders at Families in Transition in Manchester, NH 5/2010-8/2013

- Facilitated weekly treatment groups for women with co-occurring mental health and Substance misuse disorders
- Provided individual therapy services to individuals in the intensive outpatient program
- Facilitated personal assessment interviews for incoming participants
- Provided crisis assessment and intervention
- Facilitated access to community social services and resources
- Supervised Master level interns
- Documented progress notes, collateral contacts, intakes, incident reports and referrals
- Facilitated and participated in team meetings
- Provided after hours emergency pagers coverages for clients in crisis

Social Worker at Exeter on Hampton Rehab and Long Term Care Facility in Exeter, NH 5/2008 -8/2009

- Conducted biopsychosocial assessments
- Designed and implemented psychosocial plan of care for patients and residents
- Documented psychosocial assessments for Medicaid/Medicare purposes
- Assisted with discharge planning and long term care transitioning
- Worked as part of a cohesive multidisciplinary, clinical team
- Facilitated Care Plan meetings involving patients, family members and interdisciplinary team

Public Safety Dispatcher, Dover Police Department, Dover, NH 1/1984-8/2007

- Provided exceptional service in public safety communications for police and fire agencies
- Projected a calm, confident demeanor under stressful circumstances
- Accurately processed difficult situations and provided the proper course of action
- Demonstrated the emotional maturity and stability to work in a highly responsible environment

ADMINISTRATIVE AND TEACHING EXPERIENCE

Adjunct Faculty, SW 830 Graduate Social Work Practice 1

UNIVERSITY OF NEW HAMPSHIRE, Department of Social Work, August 2015 - current

- Develop, coordinate, implement, and facilitate weekly lectures, assignments, and classroom exercises for first year MSW graduate students.
- Evaluate, review, and provide written feedback on all student assignments.

AWARDS

Awarded Dover Police Department's Employee of the Year award for exceptional service

KEVIN S. IRWIN

[redacted]

EDUCATION

Yale University New Haven, CT
MA: Sociology — 2002

Syracuse University Syracuse, NY — 2000
BA: Sociology (Summa Cum Laude)

Mohawk Valley Community College Utica, NY — 1998
AAS: Human Services
AAS: Chemical Dependency Counseling

PRESENT APPOINTMENT

Senior Program Manager — 03/2012-
Government Affairs and Innovation
Corporation for Supportive Housing
61 Broadway, Suite 2300
New York, NY 10006

- Strategic Direction and Implementation of CSH Research and Evaluation Design, Quality and Management
- Housing and Health Care integration
- National and Local Program Development and Management
- Consulting, Training and Technical Assistance

PREVIOUS APPOINTMENTS

Faculty — 2008-2012
Community Health Program
Tufts University, Medford, MA

- Course instruction, including core course in US Health Care Policy, community-based health programs
- Advising, mentoring, applied learning approaches

Research Associate and Instructor — 2000- 2008
Yale University School of Public Health
Center for Interdisciplinary Research on AIDS

Direct Services Positions 1994-2000
Substance Use Counseling
Housing Support Services
Community Outreach & Education

SELECTED CONSULTANCIES (many more available)

Corporation for Supportive Housing 2003-2010
Training and Support, Policy & Procedures
Housing First: CT, RI & NJ

Connecticut Department of Public Health 2010-current
Medical Case Manager Training

Connecticut Department of Mental Health and Addiction Services 2010-2014
Trainer - Housing Case Management

New York City Department of Health & Mental Hygiene 2009-2011
Training and TA – MH Housing Programs
Working with AOD Use

AIDS Project Hartford 2011-2012
Program Management: Prevention and Harm Reduction

Citiwide Harm Reduction – Bronx, NY 2009-2010
Agency Turnaround

State of California Department of Health Services Office of AIDS 2004-2006
High Risk Initiative: Peer-Based HIV Prevention among Injection
Drug Users and Satellite Syringe Exchangers in California

Fairfax INOVA Hospital Liver Clinic 2001-2003
Hepatitis C Treatment Adherence Project
Fairfax, VA

US Department of Health and Human Services 2001-2002
RARE (*Rapid Assessment, Response, & Evaluation*)
Crisis Response Teams Initiative
Congressional Black Caucus, Office of AIDS Policy

TEACHING

Faculty 2008-2012
Community Health Program

Tufts University, Medford, MA

(CH 2) *Health Care in America*
(CH 109) *Community Action & Social Movements in Public Health*
(CH 110) *Psychoactive Drugs: Issues, Policies, and Interventions*
(CH 181) *Community Health Internship Seminar*
(CH 182) *Community-Based Participatory Research*
Homelessness and Health
(CH 185) *Community Health and Drugs*
(CH 188) *Stigma and Community Health*
(CH 189) *Seminar in Health Politics*
(AAS07) *Freshman Seminar: Arts, Sciences and HIV/AIDS*

Visiting Assistant Instructor/Professor 2007-2008
Connecticut College, New London, CT

(SOC 103) *Introduction to Sociology*
(SOC 217) *Health & Illness*
(SOC 354) *Methods of Social Research & Analysis*
(SOC 215) *Drugs & Society*
(SOC 412) *AIDS & Society*

Adjunct Instructor 2006
Connecticut College, New London, CT
(SOC 215) *Drugs and Society*

Adjunct Professor 2004, 2007
Quinnipiac University, Hamden, CT
(SO 280) *Sociology of Health and Disability*
(SO 300) *Sociology of Drug & Alcohol Use*

Instructor 2001- 2008
Yale University Center for Interdisciplinary Research on AIDS
Qualitative Research Methods and Analysis in HIV/AIDS Research

RESEARCH

Principal Investigator 2007-2011
Research & Program Evaluation – "Housing First"
Mercer Alliance to End Homelessness - Trenton, NJ
(2 ½ years: $65,000)

Co-Investigator 2007-2010
Commercial Sex Work, Sex Partners, and Drug Use: Potential HIV Bridging in Russia

(PI: Linda Niccolai, PhD)
Supported by NIDA (R21 DA025433-01)

Investigator 2009-2013
Expanding Treatment of Opioid Dependence Among the Privately Insured
(Co-PIs: Barry, Colleen, PhD, Busch, Susan, PhD)
Supported by NIDA (R01 DA026414-01A1)

Investigator 2008-
A Feasibility Study of Organizing a Community of Injection Drug Users for HIV/AIDS Prevention in Saint-Petersburg, Russia
(PI: Roman Skochilov, PhD)
Supported by NIH Fogarty International, Yale U. (#5D43TW001028)

Research Coordinator 2004- 2008
Structural Interventions and HIV Prevention Among Sex Workers and Their Clients in India (PI: Kim Blankenship, PhD)
Yale University—CIRA
Supported by: Bill and Melinda Gates Foundation

Co-Principle Investigator 2003- current
Yale University Bioethics Project
Study of Research Ethics with Active Users of Illicit Drugs
Supported by: The Donaghue Foundation, West Hartford, CT

Project Director 2003-2005
Yale University Department of Psychology
Understanding HIV-Relevant Stigma in Health Care Settings in India
(PI: Peter Salovey, PhD)
Supported by: NIMH

Research Associate 2003-2005
Yale University School of Medicine
Determining Patient and Provider Satisfaction with Office-Based Opioid Agonist Therapy (PI: David Fiellin, MD)
Supported by: Robert Wood Johnson Foundation

Research Director 2002- 2006
Yale University School of Medicine
HIV Transmission in Russia through Liquid Drug Manufacture and Injection (PI: Robert Heimer, PhD)
Supported by: NIDA (R01DA014713-01)

Co-Principle Investigator; Project Director 2002-2004
Yale University CIRA

Pilot HIV/AIDS Intervention for Crack Users in New Haven
Supported by: CIRA Development Grant

Research Assistant 2002-2005
Yale School of Medicine: IMAGE Program
(PI: Margaret Drickamer, MD)
Supported by: Reynolds Foundation Education Grant

Research Assistant 2001-2003
Yale University School of Public Health
Hispanic Health Council, Hartford, CT
SAUDA (*Syringe Access, Use, and Discard Study*)
(PI: Merrill Singer, PhD)
Supported by: NIDA (RO1DA12569-03)

Research Assistant 2000-2003
Yale University School of Medicine
Non-Occupational HIV Post-Exposure Prevention Study
Supported by: CIRA Development Grant

PUBLICATIONS

Levina, O., Heimer, R., Odinokova, V., Bodanovskaya, Z., Irwin, K.S., Niccolai, L.M. (2012) *"Sexual partners of street-based female sex workers in St. Petersburg, Russia: A model of partnership characteristics as a basis for further research"* Human Organization 71(1); 32-43.

Wheeler, E., Davidson, P.J., Jones, T.S, Irwin, K.S. (2012) *Community-Based Opioid Overdose Prevention Programs Providing Naloxone United States, 2010* Morbidity and Mortality Weekly Report. February 17, 2012 / 61(06); 101-105

Heimer, R., Dasgupta, N., Irwin, K.S., Kinzly, M. Harvey, A., Givens, A., Grau, L. (2012) *"Chronic Pain, Addiction Severity and Misuse of Opioids in Cumberland County, Maine"* Addictive Behaviors 37 (3), pp. 346-349.

Barry, D.T., Irwin, K.S., Jones, E.S., Becker, W.C., Tetrault, J.M., Sullivan, L.E., Hansen, H., O'Connor, P.G., Schottenfeld, R.S. & Fiellin, D.A. (2010) *"Opioids, Chronic Pain and Addiction in Primary Care."* Journal of Pain. 11 (12), pp. 1442-1450.

Fry, C. & Irwin, K.S. (2009) *"Engaging the Values-based Ethical Dilemmas in Harm Minimization: A Response to Weatherburn."* Addiction, 104(5), 862-3.

Barry, D.T., Irwin, K.S., Jones, E.S., Becker, W.C., Tetrault, J.M., Sullivan, L.E., Hansen, H., O'Connor, P.G., Schottenfeld, R.S. & Fiellin, D.A. (2009) *"Integrating Buprenorphine Treatment into Office-based Practice: A Qualitative Study"* Journal of General Internal Medicine, 24(2), 218-225.

Kim, D., **Irwin, K.S.** & Khoshnood, K. *"Expanded Access to Naloxone: Options for Responding to the Epidemic of Opioid Overdose Mortality."* (2009) American Journal of Public Health, 99(3), 402-407.

Grund, J.P., Zábranský, T., **Irwin, K.S.** & Heimer, R. (2009) *"Amphetamines in Central & Eastern Europe: How Recent Social History Shaped Current Drug Consumption Patterns"* in: Interventions for Amphetamine Misuse. Ed by Pates, R. and Riley, D., Wiley Blackwell, Oxford.

Irwin, K.S., & Fry, C. (2007) *"Strengthening Drug Policy and Practice through Ethics Engagement: An Old Challenge for a New Harm Reduction"* International Journal of Drug Policy, 18, 75-83.

Hanck, S.E., Blankenship, K.M., **Irwin, K.S.**, West, B.S., Kershaw, T.S. (2008) *"Assessment of self-reported sexual behavior and condom use among female sex workers in India: a polling box approach."* Sexually Transmitted Diseases, 35 (5), 489-494.

Grau, L.E., Dasgupta, N, Phinney, A., **Irwin, K.S.**, Kinzly, M. & Heimer, R. (2007) *"Illicit Use of Opioids: Is OxyContin a "Gateway Drug?"* American Journal on Addictions, 16 (3), 166-173.

Heimer, R., Booth,R.E. **Irwin, K.S.** & Merson, M. (2006) *"HIV and Drug Use in Eurasia,"* in "HIV/AIDS in Russia and Eurasia, Vol. I" Ed by Twigg, Judyth. Palgrave Macmillan: New York. 2006, 141-163.

Irwin, K.S., Karchevsky, E., Badrieva, L. & Heimer, R. (2006) *"Secondary Syringe Exchange as a Model for HIV Prevention Programs in the Russian Federation."* Substance Use and Misuse. 41 (6-7), 979-999.

Badrieva, L., Karchevsky, E., **Irwin, K.S.** & Heimer, R. (2007) *"Lower Injection-related HIV-1 Risk Associated with Participation in a Harm Reduction Program in Kazan, Russia"* AIDS Education and Prevention, Volume 19 (1), 13-23.

Drickamer, M.A., Levy, B., **Irwin, K.S.** & R. Rohrbaugh (2006) *"Perceived Needs for Geriatric Education by Medical Students, Internal Medicine Residents and Faculty."* Journal of General Internal Medicine 21 (12), 1230-1234.

Chou, W.C., Tinetti, M.E., King, M.B., **Irwin, K.S.** & Fortinsky, R.H. (2006) "Perceptions of Physicians on the Barriers and Facilitators to Integrating Fall Risk Evaluation and Management into Practice" Journal of General Internal Medicine. 21 (2), 117-122.

Martin, Lisa M., **Kevin S. Irwin,** and Zobair M. Younossi. (2002) *"Health-Related Quality Of Life and Chronic Liver Disease: Conceptual Challenges and Clinical Applications."* Clinical Perspectives in Gastroenterology, Jan/Feb, 60.

Russian Journals:

Abdala, N., Grund, J-P, **Irwin, K.S.** & Heimer, R. *"Simulating the Production of Home Made Ephedrine-based Solutions in the Laboratory: Can These Preparations Harbor Viable HIV-1?"* Russian Journal of HIV/AIDS and Related Problems, 8 (2), 2004.

Borodkina, O., **Irwin, K.S.**, Baranova, M., Girchenko, P., Heimer, R. & Kozlov, A. *"Social and Demographic Characteristics of Injection Drug Users in Russia: Results from 6 Cities."* Russian Journal of HIV/AIDS and Related Problems, 8 (2), 2004.

SELECTED CONFERENCE PRESENTATIONS & ACTIVITIES

Invited Workshop
"Person Centered Housing Services: The Promise and the Panic" Connecticut Housing Coalition Annual Conference, Hartford, CT October 17, 2013

Organizer and Facilitator
"Mass Incarceration, Racism and Homelessness" Connecticut Coalition to End Homelessness Annual Training Institute, Hartford, CT May 9, 2013

"Connecticut Integrated Health and Housing Neighborhoods – Social Innovation Fund" Connecticut Coalition to End Homelessness Annual Training Institute, Hartford, CT May 9, 2013

"Health Care and Supportive Housing Integration" CSH Eastern Region Supportive Housing Conference, Philadelphia, PA, March 7-8, 2013

"Housing Meets Health Care" Connecticut Housing Coalition Annual Conference, Hartford, CT, October 30, 2012

Invited Speaker
"Preparing Communities for Harm Reduction." Texas HIV Connection Street Outreach Workers Conference (funded by the Department of State Health Services) Austin, TX, June 20-23rd, 2010

Invited Panelist
"Crack Epidemiology: Strategies for Health." Conference of Viva Rio & Viva Communidade. Rio de Janeiro, Brazil, June 1-2, 2010

Invited Keynote Speaker
Texas HIV Connection 2009 Street Outreach Workers Conference (funded by the Department of State Health Services) Austin, TX, June 14-17th, 2009

Invited Talk
"Low Threshold Buprenorphine for Heroin Users in the US." Commission on Narcotic Drugs, United Nations, Satellite Conference: Harm Reduction in the USA: Needle Exchange and Beyond, sponsored by Harm Reduction Coalition, New York, NY. March 12, 2009, Vienna, Austria

Invited Conference Faculty
"The Epidemic of Opioid Overdose Mortality & Options for Response" Cultures in Context: HIV and Substance Abuse Research in the Southeast, Meharry Medical College, Nashville, TN, June, 2008

Invited Talk
"Mobilizing Community Expertise in HIV/AIDS Prevention Research." The Holleran Center for Community Action and Public Policy, Connecticut College, April, 2008

Invited Talk
"Options for Critical Response to the Epidemic of Opioid Overdose Mortality" The Community Health Program, Tufts University, April, 2008

Invited Conference Faculty
"Research and Active Substance Users: Making the Connection" Evidence-Based Research Ethics: Enhancing Biomedical and Behavioral Research in HIV/AIDS and Substance Abuse, Meharry Medical College, Nashville, TN, Sept, 2007

Session Organizer
"Community Organizing for HIV Prevention" Society for the Study of Social Problems Annual Meeting, New York, NY, August 2007

"Opiate Type and Risk for HIV in the Russian Federation" 17th International Conference on the Reduction of Drug Related Harm, Vancouver, B.C., Canada, May 2006

"Peer Prevention Networks: Formalizing Satellite Syringe Exchange as Public Health Practice" Society for the Study of Social Problems Annual Meeting, Philadelphia, PA, August 2005

"Imprisonment as Risk for HIV in the Russian Federation" 14th International Conference on "AIDS, Cancer and Public Health" St. Petersburg, Russia, May 2005

"The Changing Landscape of Drug Policy and Donor Funding in the Russian Federation" 16th International Conference on the Reduction of Drug Related Harm, Belfast, Northern Ireland, March 2005

"Imprisonment as Risk for HIV in the Russian Federation: Evidence for Change" 16th International Conference on the Reduction of Drug Related Harm, Belfast, Northern Ireland, March 2005

"Obstacles to the Introduction of Buprenorphine Treatment in US Office-Based Settings" 5th National Harm Reduction Conference, New Orleans, LA, November 2004

"Opening the Door on Crack: Strengthening Harm Reduction for Crack Users" 5th National Harm Reduction Conference, New Orleans, LA, November 2004

Conference Co-Organizer:
"Drug Policy and HIV Prevention in Russia: The Case of HIV/AIDS Prevention" Yale University Center for Interdisciplinary Research on AIDS: Law, Policy and Ethics (LPE) and International Core (IR) Mini-Conference, New Haven, CT, October 2004 http://cira.med.yale.edu/law_policy_ethics/dprussia_main.html

"Experiences with the Use of Buprenorphine Treatment for Opiate Addiction" New Methods of Drug Addiction Treatment and Rehabilitation: International Scientific and Practical Conference, Kazan, Russia, October 2004

"Research Partnering with Harm Reduction Projects in the Russian Federation: Results from 10 Cities" Opportunities, Challenges, and Successes of International Research; Drug Abuse and AIDS Research Center 2004 Conference, Miami, FL, August 2004

"The Re-Medicalization of Opiate Addiction: Physician Motivation and Satisfaction in the Treatment of Opioid Dependency with Buprenorphine" Society for the Study of Social Problems Annual Meeting, San Francisco, August 2004

"Ethical Standards in Research with Drug Users: Setting an International Agenda" 15th International Conference on the Reduction of Drug Related Harm, Melbourne, Australia, April 2004

"Obstacles to the Introduction of Buprenorphine Treatment in US Office-Based Settings" 15th International Conference on the Reduction of Drug Related Harm, Melbourne, Australia, April 204

"Chronic Pain and Diversion among Users of Illicit Opiates" The 6th International Conference on Pain and Chemical Dependency, Brooklyn, NY, February 2004

"Markets, Militia, and Manufacture: Liquid Drugs and HIV in the Russian Federation" Society for the Study of Social Problems Annual Meeting, Atlanta, GA, August 2003

"Community Based Participatory Research in HIV/AIDS Prevention" Society for the Study of Social Problems Annual Meeting, Atlanta, GA, August 2003

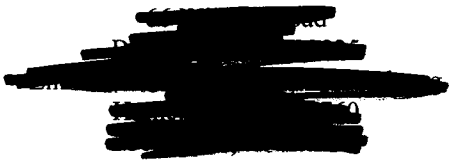
"Liquid Drug Manufacture and HIV in Russia" 14th International Conference on the Reduction of Drug-Related Harm, Chiang Mai, Thailand, April 2003

"A Peer-Driven HIV/AIDS Intervention for Crack Users" 14th International Conference on the Reduction of Drug-Related Harm, Chiang Mai, Thailand, April 2003

HONORS AND AWARDS

The Mohawk Valley Community College: The 2006 Alumni of Merit Award
Social Science Research Council: Policy Research Seminar, *Public Health, Social Welfare Systems, and HIV/AIDS in Eurasia,* 2006
Yale University Graduate Fellowship, 2000-2005
Yale University Chakerian Fellowship (Sociology/Public Health), 2000-2001
Yale Center for International and Area Studies Pre-dissertation Grant, 2001
Syracuse University Remembrance Scholar, 1999
Syracuse University Excellence Scholarship, 1998-2000
Syracuse University Honors Program, 1998-2000
American Sociological Association Honors Program Participant, 1999
Best Undergraduate Paper: NYS Sociological Society Conference, 1999
John Stratton Memorial Scholarship, 1998

Erin E. Ross



Objective

Obtain a position in Health Care, which will continue to build knowledge and skills from both education and experiences gained.

Qualifications

Mature, energetic individual possessing management experience, organizational skills, multi-tasking abilities, good work initiative and communicates well with internal and external contacts. Proficient in computer skills.

Education

September 1998 – May 2002 **Bachelor of Science in Health Management & Policy**
University of New Hampshire
Durham, New Hampshire 03824

Related Experience

July 2011 – Present **Chief Financial Officer**
Goodwin Community Health

- Responsible for financial oversight of center to include supervision of accountant, bookkeeper, billing department and all clinical administrative staff.
- Assist Executive Director in budgeting process each fiscal year for center.
- Generate and assist with financial aspects of all center grants received.
- Complete on an as needed basis finance analysis's of various agency programs.
- Participate in agency fiscal audit at the end of each fiscal year.
- Member of Board of Directors level Finance Committee

August 2006 – June 2011 **Service Expansion Director**
Avis Goodwin Community Health Center

- Responsible for the overall function of the Winter St location of Avis Goodwin Community Health Center.
- Maintain all clinical equipment and order all necessary supplies.
- Coordinate the scheduling of all clinical and administrative staff in the office.
- Assist with the continued integration of dental services and now mental health services to existing primary care services.
- Assist with the integration of private OB/GYN practice into Avis Goodwin Community Health Center.
- Organize patient outcome data collection and quality improvement measures to monitor multiple aspects and assure sustainability for Avis Goodwin Community Health Center.

January 2005 – August 2006 **Site Manager, Dover Location & Front Office Manager**
Avis Goodwin Community Health Center

- Responsible for the overall function of the Dover location of Avis Goodwin Community Health Center.
- Maintain all clinical equipment and order all necessary supplies.
- Assist with the continued integration of dental services and now mental health services to existing primary care services.
- Coordinate the scheduling of all clinical and administrative staff in the office.
- Organize patient outcome data collection and quality improvement measures to monitor multiple aspects and assure sustainability for Avis Goodwin Community Health Center.
- Supervise, hire and evaluate front office staff of both Avis Goodwin Community Health Center locations.
- Develop and implement policies and procedures for the smooth functioning of the front office.

May 2004 – January 2010 **Dental Coordinator**
Avis Goodwin Community Health Center

- Supervise, hire and evaluate dental staff, including Dental Assistant and Hygienists.
- Acted as general contractor during construction and renovation of existing facility for 4 dental exam rooms.
- Responsible for the operations of the dental center, development of educational programs for providers and staff and supervision of the school-based dental program.
- Developed policy and procedure manual, including OSHA and Infection Control protocols.

- Organize patient outcome data collection and quality improvement measures to monitor dental program and assure sustainability.
- Maintain all dental equipment and order all dental supplies.
- Coordinate grant fund requirements to multiple agencies on a quarterly basis.
- Oversee all aspects of billing for dental services, including training existing billing department staff.

July 2003 – May 2004 **Administrative Assistant to Medical Director**
Avis Goodwin Community Health Center

- Assist with Quality Improvement program by attending all meetings, generating monthly minutes documenting all aspects of the agenda and reporting quarterly data followed by the agency.
- Generate a monthly report reflecting provider productivity including number patients seen by each provider and no show and cancellation rates of appointments.
- Served as a liaison between patients and Chief Financial Officer to effectively handle all patient concerns and compliments.
- Established and re-created various forms and worksheets used by many departments.

December 2002 – May 2004 **Billing Associate**
Avis Goodwin Community Health Center

- Organize and respond to correspondence, rejections and payments from multiple insurance companies.
- Created an Insurance Manual for Front Office Staff and Intake Specialists as an aide to educate patients on their insurance.
- Responsible for credentialing and Re-credentialing of providers, including physicians, nurse practitioners and physician assistants, within the agency and to multiple insurance companies.
- Apply knowledge of computer skills, including Microsoft Office, Logician, PCN and Centricity.
- Designed a statement to generate from an existing Microsoft Access database for patients on payment plans to receive monthly statements.
- Assist Front Office Staff during times of planned and unexpected staffing shortages.

June 2002 - December 2002 **Billing Associate**
Automated Medical Systems
Salem, New Hampshire 03079

- Communicate insurance benefits and explain payments and rejections to patients about their accounts.
- Responsible for organizing and responding to correspondence received for multiple doctor offices.
- Determine effective ways for rejected insurance claims to get paid through communicating with insurance companies and patients.
- Apply knowledge of computer skills, including Microsoft Office, Accuterm and Docstar.

Work Experience

October 1998 – May 2002 **Building Manager**
Memorial Union Building – UNH
Durham, New Hampshire 03824

- Recognized as a Supervisor, May 2001-May 2002.
- Supervised Building Manager and Information Center staff.
- Responsible for managing and documenting department monetary transactions.
- Organized and led employee meetings on a weekly basis.
- Established policies and procedures for smooth functioning of daily events.
- Oversaw daily operations of student union building, including meetings and campus events.
- Served as a liaison between the University of New Hampshire, students, faculty and community.
- Organized and maintained a weekly list of rental properties available for students.
- Developed and administered new ideas for increased customer service efficiency.

References

Available upon request

GOODWIN COMMUNITY HEALTH

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Janet Laatsch	Chief Executive Officer	$147,514	0%	$0
Susan Gordon	Director of Behavioral Health	$64,646.40	0%	$0
Kevin Irwin	Public Health Director	$80,995	0%	$0
Erin Ross	Chief Financial Officer	$96,720	0%	$0